FEBRUARY 2003 • VIMALA RAMACHANDRAN

Background Study for the Swedish Country Strategy for India 2003–2007

Social Sector Reforms in India

Foreword

India has made much progress along several dimensions of human development over the past three decades. Since the mid-1970s, GDP per capita has more than doubled, the average life expectancy at birth has increased by 13 years, and the infant mortality rate has fallen by half. However, despite these considerable achievements, adult literacy rates remain low, maternal mortality rates remain high and almost half of all children under age three years are undernourished. Many schools and health centres are underfunded and underequipped and both the education and health sectors are in need of reforms.

The Swedish International Development Cooperation Agency (Sida) is currently preparing a new Country Strategy for the development co-operation between Sweden and India. In order to provide the Embassy with information on social sector reforms in India we asked a team of consultants to:

- Review and analyse the social sector reform initiatives in India,
- Elaborate on what impact social sector reforms have had on the health and literacy outcomes and overall well-being of the people,
- Identify areas currently in need of reforms in the health and education sectors, and
- Make recommendations to Sida on priorities, principles and possible areas for future Swedish support.

We are pleased to share with you their findings and recommendations.

New Delhi, February 2003

Owe Andersson

Counsellor and Head
Development Cooperation Section
Embassy of Sweden

Published by Sida 2003

Embassy of Sweden, New Delhi

Author: Vimala Ramachandran, Gita Sen, Harsh Sethi, Leela Visaria, Rama Baru,
Ravi Duggal, Sunil Nandraj, V. R. Muraleedharan

Printed by Elanders Novum AB, 2003

Art no: SIDA2188en

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List of abbreviations

ANM	Auxiliary Nurse Midwife
AS	Alternative School
CEHAT	Centre for Health Awareness and Training (A Mumbai Based NGO)
CPR	Couple Protection Rate (Contraceptives)
CNA	Community Needs Assessment – a micro planning approach adopted by GOI for the RCH programme.
DANIDA	Danish International Development Agency
DFID	Department for International Development, United Kingdom
DIET	District Institute of Education and Training.
DOE	Department of Education
DPEP	District Primary Education Project
EAP	Externally Aided Project
EC	European Commission
ECCE	Early Childhood Care and Education.
EFA	Education For All
EGS	Education Guarantee Scheme of the Government of Madhya Pradesh
FP	Family Planning
GDP	Gross Domestic Product
GOI	Government of India
HIV-AIDS	Human Immunodeficiency Virus – Acquired Immunodeficiency Syndrome
HSR	Health Sector Reforms
ICDS	Integrated Child Development Services/Scheme
ICPD	International Conference on Population and Development, Cairo
JRM (DPEP)	Joint Review Mission
MCH	Maternal and Child Health
MHRD, GOI	Ministry of Human Resources Development, Government of India
MMR	Maternal Mortality Rate
MOHFW, GOI	Ministry if Health and Family Welfare, GOI
MTR	Mid Term Review
NACO	National Aids Control Organisation
NCAER/HDI Survey	A Human Development Indicator Survey done by National Council of Agricultural Research, New Delhi
NCERT	National Council of Educational Research and Training, new Delhi
NCLP	National Child Labour Programme
NFE	Non Formal Education
NFHS	National Family Health Survey (I and II)
NGO	Non Governmental Organisations
NIEPA	National Institute of Educational Planning and Administration, New Delhi

NSS/NSSO	National Sample Survey Organisation of GOI
OBC	Other Backward Classes (A constitutional category used in India)
PNDT Act	(Prevention of misuse of) Pre-Natal Diagnostic Technology Act of GOI.
PDS	Public Distribution System
PHC	Primary Health Centre
PRI	Panchayati Raj Institutions (Local Self Government Institutions)
PTA/MTA	Parent Teacher Association/Mother Teacher Association
RCH	Reproductive and Child Health
SSA	Sarva Shiksha Abhiyan: Campaign for universal education, GOI.
SC – Scheduled Caste	Socially disadvantaged groups that have been listed in the IX Schedule of the Constitution of India – from erstwhile community of "untouchables".
SCOVA	Standing Committee on Voluntary Action
SHG	Self help groups
SKP	Shiksha Karmi Project Rajasthan
SRS	Sample Registration System
SSA	Sarva Shiksha Abhiyan (Campaign for Education for All – GOI)
ST – Scheduled Tribe	Tribal Groups that have been listed in the IX Schedule of the Constitution of India
TLC	Total Literacy Campaign
UEE	Universalisation of Elementary Education
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's' Fund
USAID	United States Agency for International Development
VEC	Village Education Committee
WHO	World Health Organisation

1 Executive Summary

1. Sida has been an important player in both primary education and women's health in India and has been quite important in flagging women's health issues within primary healthcare and bringing centre stage issues of maternal mortality, safe abortion and most importantly weaving a gender perspective into social sector programmes. This is also true in the education sector, Sida's partnership with Government of India programmes in the field of primary education led to valuable lessons in need based planning, decentralisation and government-NGO partnerships. Similarly, Sida's NGO programmes in the social sectors have taken the rights perspective as a point of departure and therefore been an important learning ground in health and education.

2. Poverty is not only about income, it also encompasses factors like health, education, nutrition and access to basic needs and services. The extent of poverty, social and gender inequality, good governance and geographic location are factors that influence health and nutritional status of people and the utilisation of health services. Indifferent performance on the poverty front, combined with growing doubts about the affordability and access of health services to the poor, and the slow pace of health system reforms pose major challenges to the reproductive health programme of the Indian government. There is now a global recognition that the effectiveness of programmes promoting reproductive health and rights depends critically on broader health system issues that affect both the demand for and the supply of health services. Reproductive health cannot be handled independently of the functioning of the health system, especially so in India where the Reproductive and Child Health Programme (RCHP) is implemented through the existing primary and tertiary healthcare delivery system. Health system reforms need to take these issues directly into its ambit if the poor as well as women are to be able to afford and access health services, whether public or private. Besides this, health sector reforms as such have been relatively slow to take off in India.

3. Similarly, in the education sector, issues of poverty and social access have to be brought centre stage. Education lies at the heart of development and is central to the achievement of greater equality – both social and gender equality. A staggering number of children, 38.41 per cent of boys and 51.88 per cent of girls in the age group 6-14 are not attending school. A new trend, less recognised, is the coexistence of a multiplicity of schools – government primary schools, Education Guarantee Scheme (EGS) schools, alternative and private (recognised & unrecognised). *This process has significant implications for both social policy and social typecasting.* The rapid growth of EGS schools or Shiksha Karmi schools has revived the old debate of dualism in education, a process further exacerbated by the proliferation of private schools. Unlike the health sector – there is no 'formal' reform programme that is underway at the moment. Most systemic issues were addressed in the National Policy on Education (1986), Programme of Action (1986 and 1992) and most recently the Sarva Shiksha Abhiyan 2001 (SSA).

4. The fiscal situation of the state governments is worrisome especially in view of the fact that state governments shoulder the primary responsibility for primary health care and basic education. Given this situation, the government (with or without external aid) is expected to play a positive role in enhancing access and improving quality in education and health.

5. The overarching challenge faced by India is to improve the health, nutrition and education status of the poor, particularly women and girls. Linking social sector programmes to poverty alleviation is critical. The biggest challenge facing the country is to approach the problem from below and explore how services and opportunities can reach the needy – thereby integrating gender and social

equity issues into sector reforms. Making community participation the point of departure for planning and priority setting could indeed bring about synergy between the social sectors and poverty alleviation.

6. Another challenge faced in the country is to ensure that both health and education are geared to quality. This has far-reaching consequences for the health of poor women, children and old people. While an overall decline in access, infrastructure, functionality, quality and attitudes affect all, given the prevailing social inequalities and hierarchies, these factors affect the poor (adults and children) and among them girls, much more than they affect the more privileged sections of society. The latter are increasingly opting out of public services. Even when the privileged sections of society use government health services, they do so through positions of strength and authority. Similarly when they do use government schools, private tuition often supplements school instruction.

7. There is a synergetic relationship between the public and private sectors. It is widely recognised that quality and cost of services in the public sector influences quality in the private sector – the two are linked. Where the public sector is dysfunctional the private sector is equally bad and costs are high. Conversely, where the public sector is functioning and is of reasonable quality, both cost and quality in the private sector is not that high.

8. The recommendations that follow, focus on those programme ideas that directly address not only gender and equity issues in access, but also on processes that would strengthen decentralisation and community participation. The main recommendations made are as follows:

Health and nutrition:

- District focused operation research initiatives to strengthen community need based planning and priority setting within the health system. This could be achieved if Sida focused on a few districts in the country and supported a grassroots approach in identifying the needs of the people. This would ensure involving the community in assessing their health status and help search for ways and means to tackle various issues and problems – with a concerted effort made to involve and respond to women.

- Sida could work with the national government to develop and refine the idea of creating a pool of nurse-midwives who could be the first line of care givers in rural areas and urban slums/migrant settlements. Sida could begin with advocacy/preparing the ground in India – in collaboration with a premier institution in Sweden. Sweden could bring into this process their experience and expertise – to convince the medical community of both the need for nurse-midwives and the importance of enhancing their status and their skills/confidence to be able to function in the community.

- Establish a best practices inventory in the health sector reforms (HSR) process in India and explore the possibility of supporting a (non-government) network to monitor the process. This could be done in collaboration with a premier institution/network that could become the nodal point for an informed debate on pro-poor and en-gendered sector reforms.

Literacy and Education:

- Sida could consider supporting the Government of India's newly announced National Programme for the Education of Girls at the Elementary Level (NPEGEL) – which is expected to be initiated in 200 educationally backward blocks, Sida's support would go into developing context specific strategies in different parts of the country.

- Work with the Indian government to develop context specific strategies for child labour and working children – especially in urban and peri-urban areas.

9. In conclusion, Sida as a small donor should seek to focus on programmes wherein it might enjoy some advantage particularly while dealing with marginalized groups, predominantly women and girls. Special care must be taken that the programmes developed are based on a rights perspective and are cost-effective to facilitate easier mainstreaming.

2 Introduction

For over three decades now, at least since the 1970s, people involved in development work and struggle for social justice and democracy in India have had to periodically redefine their priorities and adjust to newer challenges. In the early years after Independence, there was a sense of euphoria that inspired confidence in the democratic fabric of our society. Social reformers and those involved in political movements channelled their energies into welfare and development. India has come a long way since then. While the democratic fabric of society has been strengthened, the rights of different sections of the population especially minority groups, disadvantaged communities and tribal populations, continues to pose a challenge.

In the 1990s the concept of rights acquired an entirely new meaning. Many decades of development assistance through government sponsored and executed anti-poverty programmes and innumerable donor assisted development projects barely changed the situation on the ground. This prompted a former Prime Minister to comment that barely fifteen per cent of developmental resources reach those it is meant for – the rest either leaks out or is absorbed by layers of middlemen. People's traditional right of access to common property resources, forests, rivers and ponds have also been gradually eroded. The unscrupulous practices of private and public factories, tanneries and workshops have not only polluted land and rivers but have grave health consequences. Social activists and voluntary groups watching leakage of precious resources meant for the poor and the asset-less mounted a campaign for people's right to information on allocation and expenditure of resources meant for developmental work.

The last two decades have witnessed many struggles, small and big, against erosion of people's right to live in dignity and in a safe environment. Rising social strife and increasing polarisation of society has led to greater societal and domestic violence. This has resulted in violence, perpetuation of customs like dowry and a renewed legitimacy of caste, community based mobilisation, and growing fundamentalism of non-secular organisations. All these factors have challenged liberal democratic notions of equality and freedom. This phenomenon affects women within the household and also impinges on the opportunities and spaces available for them in the community and society.

As a result the contemporary discourse on rights in India is increasingly conducted in a tone of despair and weariness. Most actors recognise that the major challenge before India is to expand the definition of rights in civil society. Those involved in developmental work have understood the importance of traditional rights over forest produce, the effects of eviction, logging, pollution, dumping of industrial waste on common land, medical malpractice, illegal drugs and contraceptives. While the discourse on rights is often confined to issues of social and political rights vis-à-vis the state and occasionally the community, the importance of dealing with market forces has added yet another dimension to the rights issue. The new economic policy and the ushering in of the era of globalisation have brought forward another challenge – the market. Increasingly basic services like education, health, shelter, even water is being provided by the 'private sector¢, which can raise the resources and the poor are rendered defenceless in the face of capricious market forces.

People have been pushed into demanding some form of regulation by the government in the face of pressure from the problems of daily living. Environmental pollution of small factories/industries polluting water sources, common grazing land, air etc. affects the quality of life of people as never before. Increasing incidence of medical malpractice like removal of uterus without ascertaining its necessity, unnecessary organ transplants, prescription of unsafe or banned drugs, indiscriminate use of ultra-sound machines, clandestine sex determination tests followed by second trimester abortion, unethical contraceptive and vaccine trials add to their burdens. Fortunately, in the last five years, social action groups and citizens fora have realised that government regulation does not necessarily guarantee compliance and that a strong consumer movement would be necessary to deal with market forces.

This document is framed within a larger human rights perspective – one that acknowledges the criticality of women's agencies and indeed the agency of the poor in determining priorities and monitoring impact.

This document has been compiled as an input into the country strategy preparation of the Swedish International Development Co-operation Agency (Sida) for the period 2003-2007. As we all know, no single document can capture the range of issues and concerns and the complexities that frame social sector policies in India. The following analysis primarily focuses on primary health care, elementary education and literacy and does not purport to capture the entire social sector. An effort has been made to draw upon the wealth of research studies, policy analysis and government documents. We have drawn from the valuable insights of the Mid Term Review of the Ninth Five Year Plan of the Planning Commission of the Government of India, ongoing debates on National Population Policy, Draft Health Policy, reviews of the District Primary Education Programme and the Sarva Shiksha Abhiyan (SSA): Campaign for Universal Education, Government of India document.

Sida has been an important player in both primary education and women's health in India. It has supported several pioneering and path breaking programmes like the Shiksha Karmi Project (SKP) and the Lok Jumbish of Rajasthan. This enables Sida to play a positive catalytic role in elementary education. Similarly, over a decade of assistance to the Child Survival and Safe Motherhood (CSSM) programme has contributed towards flagging women's health issues within primary healthcare and bringing centre stage issues of maternal mortality, safe abortion and most importantly weaving in a gender perspective into social sector programmes. Sida's support to NGO programmes in the social sectors has taken the rights perspective as a point of departure and therefore been an important learning ground in health and education.

Vimala Ramachandran
6 May 2002.

3 Health and Nutrition

3.1 Poverty, gender relations and health

Poverty is a function not only of income but also of factors like health, education, nutrition and the ability to access basic needs and services. The extent of poverty, social and gender inequality, good governance and geographic location influences the health and nutritional status of people and the utilisation of health services. Notwithstanding decades of poverty alleviation and income generation programmes and an average rate of economic growth of GDP of about 5 per cent per year, the country's performance on the poverty alleviation front has been disappointing, especially during the 1990s. Anti poverty programmes showed a sharp increase in the first half of the decade and only a modest improvement in the latter half of the 20th century.

Although urban poverty declined steadily, the rural poverty headcount ratio was at the same level at the beginning and the end of the decade after a worsening in the middle of the 1990s. The impact of rising food prices on the real consumption of the poor and of stagnant rural employment opportunities continues to be a matter of significant concern. A sharp decline in the off-take of the public distribution system (PDS) food grains by states where poverty is concentrated is the result of a combination of fiscal pressures on state budgets and the effect of policies resulting in higher prices for food grains. Besides this, the increasing debt ratio and interest payment in the 1990s in contrast to the 1980s, when the growth rates were at similar levels, worsened the scenario. The implications of these trends on the nutritional levels of the poor and especially of women and children are deeply worrying.

Indifferent performance on the anti-poverty programme front, combined with growing doubts about the affordability and access of health services to the poor, and the slow pace of health system reforms pose major challenges to reproductive health. This is particularly so in the context of widespread and persistent gender bias in nutrition and health care that exists at the household level in many parts of the country. In the face of rising costs of care, including hidden costs, it is likely that women find it increasingly difficult to access formal health care and experience recurring bouts of untreated illness. Non-treatment tends to be more prevalent in the reproductive age groups, as women tend to leave untreated those conditions that are chronic but perhaps not completely incapacitating like certain reproductive tract infections and mental stress.

There is now a global recognition that the effectiveness of programmes promoting reproductive health and rights depends critically on broader health system issues that affect both the demand for and the supply of health services. In India, reproductive health cannot be tackled independently of the functioning of the health system, since the reproductive and child health (RCH) programme is implemented through the existing primary and tertiary healthcare delivery system. Unfortunately not much is happening by way of long term reform in the health system.

It is worrying to note that in the past decade the pace of improvement in key health status indicators appears to have slowed down and in some cases even stalled. The rate of decline in infant mortality has been slow in the 1990s; in fact perinatal and neonatal mortality has not fallen and their share in the total infant mortality has increased. Reviewing the working of the 9th Five Year Plan, the Planning Commission has expressed concern at the decline in routine immunisation of children against the major vaccine-preventable diseases. This fact is also borne out by the data from the first and the second rounds of the National Family Health Survey (NFHS) conducted in 1992-93 and 1998-99. The NFHS also showed that maternal mortality has remained unchanged at an unacceptable high level.

A comparison of data from the National Sample Surveys (NSS) in the late 1980s and mid-1990s, points to significant increases in the cost of both in-patient and outpatient healthcare in rural and urban areas. Detailed analysis of the NSS data shows that untreated illness among the poor has clearly increased due to financial constraints. Inequity as measured by figures of the household consumption expenditure group appears to have worsened, and the divide between rich and poor in terms of untreated illness and expenditure on health services, as well as their use of both public and private health care institutions, has grown. The rich are now the major users not only of private but also of public hospitals[1]. Increased drug costs and rising fees for different health services in both the private and public sector seems to have played a major role in this[2]. The rising cost of healthcare can have a range of possible effects on the poor. These include cutbacks on other consumption like food, which directly impacts on nutrition and health status; growing untreated illness; and growing gender biases in health seeking behaviour. *Left un-addressed, in future this may well mean that even if reproductive or other health services are made available, the poor may not be able to access them*.

These developments imply major challenges for the reproductive health agenda. Health system reform needs to take these issues directly into its ambit if the poor as well as women are to be able to afford and access health services, whether public or private. Health sector reforms have been relatively slow to take off in the country. In some ways, this may not be all that deplorable, other countries too resorted initially to a 'cookie-cutter' approach, prioritising efficiency over equity, in their first generation of health sector reforms. In India major donor-supported projects have been launched, but the slowness of health system improvements makes it difficult to draw lessons from them. It has also prevented forward movement on issues that may be critical to the effective advancement of programmes related to reproductive health and rights. These issues would include affordable cost and access to services, decentralisation and devolution to Panchayati Raj Institutions (PRIs), community needs-based planning, sustainability of infrastructure and workforce, and improved quality of services.

Despite being a signatory to the Plan of Action of the Fourth World Conference on Women held at Beijing in 1995 and to the Vienna Conference on Human Rights, India has been slow in implementing measures that ensure gender equity and women's empowerment in all spheres. However, some important initiatives were taken during the last decade. The implementation of the 73rd and 74th amendments to the Constitution of India giving women a reservation of a third of the seats in elected local government bodies, and the setting up of the National Commission for Women were steps in the right direction. But translation of these into action is fraught with many problems and opposition. Whether the recently approved National Policy for Women's Empowerment will bring about a change still remains to be seen.

[1] Until the mid-1980s, public hospitals were still the dominant providers of in-patient care especially for the poor, even though patients were increasingly resorting to the private sector for outpatient services. Although this varied considerably across states, public hospitals provided an important alternative to the private sector and at significantly lower cost. By the mid-1990s, there is clear evidence that the private sector had become dominant in terms of both outpatient and in-patient services (Gita Sen et al, forthcoming 2002).

[2] Fees for service are being increasingly used as part of decentralisation and in order to increase financial viability. However, globally, support for user fees has declined for three main reasons: (i) the net revenue earned is insignificant; (ii) effective targeting is difficult and its absence reduces demand for health services by the poor and women; (iii) separation of users into two categories of those who pay and those who don't leads to significant quality differentials, and also reduces the political support for free or subsidised services.

Women's access to healthcare

Economy, society & culture	Systemic issues	Mindset and attitudes
Poverty & powerlessness	Physical access	Population control mindset
Status of women	Availability of providers	Focus only on women in reproductive age groups
Caught up in survival battles	Dysfunctional facilities	Gender stereotyping and gender-bias
Perception of self	Location and timing	Attitude of service providers towards the poor, especially women
Post puberty practices and child marriage	Quality of care	Absence of a rights perspective
Burden of work/domestic chores	Clinical skills of providers	
Domestic violence	Women specific services	
	Multiple windows for interrelated services	
	Reliable referral services	

Gender relations, socio-economic status and human rights affect attitudes, access and quality.

At the societal level, gender bias persists in key areas in the form of society's preference for boys over girls, the continuation of the dowry system, early marriage and violence, including sexual violence against women in both private and public spaces and women's lack of decision-making powers. Only 52 per cent of women reported being involved in decisions even when it concerned their own healthcare. Barring Kerala, the juvenile sex ratio has worsened in every major state, even though there has been some improvement in the overall sex ratio. Perhaps the most striking evidence on women's low status is that 21 per cent (NFHS-2 1998-99) reported being victims of domestic violence from age 15 on. Illiterate and poorer women experienced higher than average rates of violence.

Women's empowerment and their access to reproductive and sexual rights depends on literacy and higher educational attainment. Although in the last decade women's literacy has shown an appreciable increase, only 54 per cent of women (as opposed to 76 per cent of men) were reported literate in the 2001 Census. The significant increase in female literacy from 39.3 per cent in the 1991 Census has meant a reduction in the male-female literacy rate gap from 24.8 to 21.7 percentage points. We still have a long way to go in providing equity in education to both boys and girls, which would enhance women's status in family and society.

3.2 Issues, concerns and trends

Progress on health reforms has at best been piecemeal and sporadic. Although there is a recognition and widespread acknowledgement of the importance of gender justice and social/economic disparities as the major barrier to realising the goal of health for all. At the same time, one must recognise that there have been significant improvements in certain health indicators. Life expectancy at birth, for instance, has increased from 49 years in 1970, with a female disadvantage, to 63 years in 1998 or at the rate of half a year per annum. Proverbially, in India, female life expectancy was lower than that of men for several decades. This has reversed since the 1990s, over the last decade female life expectancy is a little over a year higher than male life expectancy.

Infant mortality rate has also dropped. In a span of 40 years it has fallen from 146 per 1000 births in the 1950s to less than half that level or to 70 in 1999; the gain even by world standards is quite impressive (World Bank, 2001)[3]. However, the sluggish pace of decline in infant mortality in the 1990s compared to the previous decades has been a cause of concern. An additional concern is that the rural-urban gap in

[3] If the IMR of 146 in the 1950s is an under-estimate, as many analysts believe, then the pace of decline has been even greater.

infant and child mortality has marginally increased reflecting stagnation and decline in rural health services. Except for the pulse polio campaign, the slow down in basic health interventions and immunisations seems to be partially responsible for the slow down in the pace of decline in infant and child mortality. Data compiled by the Sample Registration System (SRS) suggest that neo-natal mortality or mortality in the first 28 days of life is disturbingly high in India at about 53 per 1000 live births and has been declining at a slower pace compared to the decline in the post-neonatal phase. The slow pace in the decline of neonatal mortality is linked to maternal factors such as early age of marriage and childbirth, and low utilisation of antenatal care and obstetric services. According to the recent NFHS data only two-thirds of all women (and two in five rural women) had received even one ante-natal check-up from a doctor or other health professional; only 54 per cent of pregnant women were fully immunised against tetanus, and just about half had received iron supplementation. Further, two out of three Indian women depended on untrained birth attendants and three out of four babies are delivered at home, usually in unhygienic conditions. This leads to poor birth outcomes resulting in low birth weight and premature babies as well as poor maternal health.

India has an estimated maternal mortality ratio (MMR) of about 540 (NHFS-2) – one of the highest levels in Asia. Researchers point out that even this estimate is not reliable. We have no state level estimates. Practitioners admit that even though difficult it is not impossible to make special efforts to arrive at reasonable estimates. The government is yet to analyse existing data available in Auxiliary Nurse Midwife's (ANM) records. Although national level estimates of maternal mortality are rare, evidence from a few micro level estimates suggests that there has been little or no change in the level in the last 15 years. Each year more than 100,000 women in their reproductive age span die due to pregnancy-related causes. World-wide, it has become increasingly evident that nearly two-thirds of all maternal deaths occur after delivery or during the postpartum period and more than 80 per cent of them occur within two weeks of delivery. Direct obstetric complications such as sepsis or infection, toxaemia and haemorrhage are the major causes of these maternal deaths. Even though some of the causes cannot be anticipated, ways to manage many of the complications that arise during pregnancy, delivery and in the postpartum period are known and are effective in preventing death. The emphasis on promoting institutional deliveries and combating anaemia during pregnancy by distribution of iron and folic acid tablets, though good for the well being of the mothers, contributes marginally to lowering maternal mortality.

According to the NFHS-2, a health worker visited only 16 per cent of Indian women within two months and barely 5 per cent within one week of birth. Non-availability of obstetric care stems from a complex interplay of several factors. These range from the low socio-economic status of women, little autonomy in taking decisions about their own health, inability in accessing healthcare services, lack of or little control over resources, etc. In other words, since women's health in general and reproductive health in particular is situated in the larger socio-cultural milieu, it is important to understand the impediments that women face in accessing care and services.

The HIV/AIDS scenario is also deeply worrying. According to NACO the latest estimate for the HIV/AIDS infected adult population in the country is 3.8 million. Available surveillance data indicates that HIV is prevalent in almost all parts of the country and that more and more women attending antenatal clinics are testing HIV positive. It is estimated that 85 per cent of the infections stem via the sexual route, 4 per cent through blood transfusion and 8 per cent through injecting drug use (NACO 2002)

Little is known about adolescent reproductive health in India. Adolescents account for 22.8 per cent of the population (according to the Planning Commission's Population projections as on 1st March 2000) – i.e. about 230 million Indians are in the age group of 10 to 19 years. NFHS-2 data reiterate that early marriage and childbearing continue to be universal in India. The median age at marriage is about 16 years and a significant proportion of adolescent girls become pregnant before attaining full physical de-

velopment. While exact estimates are not available, it is believed that the incidence of spontaneous abortion among girls aged 15-19 is higher compared to that of women in the 18+ age group. Uneven educational opportunities, compulsion to work both at home and outside, poor nutrition and lack of access to adequate food, increasing stress (of both school going and out-of-school adolescents) and violence, lead to a range of biological, social and psychological problems.

Reviewing health programmes in the country together with the range of special programmes (disease control, reproductive and child health included) reveals that the existing primary health care delivery system along with several layers of referral hospitals does not cater to the health needs of adolescents. Population education and other reproductive health programmes do not factor in the general health and nutritional requirements of this very significant section of the population. The ICDS programme incorporated distribution of iron and folic acid tablets to adolescent girls, but its efficacy and impact are yet to be assessed. Moreover, adolescents have nowhere to go for counselling services.

The RCH programme provides for services for married adolescent girls, but not for boys. Sexual health education of boys is discussed, among other issues, in various approach papers for managing the HIV/AIDS pandemic. Though these programmes are noteworthy, there is growing evidence of a tremendous lack of awareness of their bodies and of sexual behaviour, both among boys and girls and there is considerable interest among them in filling this gap in knowledge. What is, therefore, urgently required for both adolescent girls *and* adolescent boys are programmes that help deal with their own well being, their health, their bodies and their sexual lives. This is particularly important in the light of the HIV/AIDS pandemic. The Planning Commission Working Group on Adolescents (June 2001) points out that "Nutrition, health (physical and mental) and education are interlinked and recognising these linkages in policies and programmes is essential if we are to make any headway in the overall development of adolescent girls and boys in India".

HealthWatch (1999) studies conducted in several states reveal that quality of health care, especially of women, continues to remain a serious concern. The studies indicated that there was no change in the service environment even where technical quality indicators were followed. Counselling is equated with motivation for family planning. Although most advocates agree that a meaningful partnership between community, private sector and public sector through a representative committee at the functional level could enhance the quality of service, operationalisation of such efforts is rare. In fact, community participation and private co-operation for construction, maintenance, supplies and non-medical support to health related employment has been demonstrated as an effective strategy[4]. Statutory provision of community needs assessment protocols, representative committees and community forums are necessary *but do not provide a sufficient condition* for meaningful participation. What is needed is to strengthen the capacity of rural women leaders to help them negotiate the health delivery system from a position of strength so that they can make informed choices. In short, we still have a long way to go in improving the quality of services and to make it more client-centred.

Notwithstanding the problems and the challenges, the RCH programme has created space for addressing women's health issues and has succeeded in enlarging the mandate of the government family welfare programme. The two NFHS surveys, the recent Census 2001 and a number of qualitative studies have forced the Indian government, the NGOs and the donors to look at women's health in a more holistic manner. Sex selective abortion, maternal mortality, access to basic healthcare services, violence against women, the gender and social context of sex, sexuality and reproductive rights (highlighted in the wake of the HIV/AIDS pandemic) – all these are now debated in public. The good news is that there is space

[4] The Tamil Nadu experience has been documented in Visaria and Visaria in HealthWatch Studies, 1999.

to discuss these issues under the aegis of the RCH programme. This is no mean achievement in a country that witnessed forty-five years of a narrow family planning and population control programme where women were primarily viewed as targets.

3.3 Government policy and budget allocations:

Based on the observations and recommendations of the Mid Term Review of the Ninth Five Year Plan, the Tenth Five Year Plan of the Government of India has set overarching goals for the period 2002-2007[5]. They are:

- Universal access to primary education by 2007.
- Reduction in the decadal rate of population growth between 2001 and 2011 to 16.2 per cent;
- Increase in literacy rates to 72 per cent by 2007 and to 80 per cent by 2012;
- Reduction of infant mortality rate (IMR) to 45 per 1000 live births by 2007 and to 28 by 2012;
- Reduction of maternal mortality ratio (MMR) to 20 per 1000 live births by 2007 and to 10 by 2012.
- All villages to have access to potable drinking water by 2012.

The Approach Paper to the 10th Plan categorically states that "There will have to be a continued commitment to provide essential primary healthcare, emergency life saving services, services under the National Disease Control Programmes and the National Family Welfare Programme free of cost to individuals, based on their needs and not on their ability to pay. At the same time, suitable strategies will have to be evolved, tested and implemented for levying collecting and utilising funds obtained for healthcare services from people above poverty line… Data from NSSO indicate that escalating healthcare costs is one of the reasons for indebtedness not only among the poor but also in the middle-income group. It is, therefore, essential that appropriate mechanisms by which cost of severe illness and hospitalisation can be borne by individual/organisation/state are explored and affordable appropriate choice made. Global and Indian experience with health insurance/health maintenance organisations has to be reviewed and appropriate steps initiated… One of the major factors responsible for poor performance in hospitals is the absence of personnel of all categories who are posted there. It is essential that there is appropriate delegation of powers to Panchayati Raj Institutions (PRIs) so that there is local accountability of the public healthcare providers, and problems relating to poor performance can be sorted out locally" (Planning Commission, GOI, 2001, Paragraph 3.28 to 3.32).

What is the fiscal situation – where is India placed in this regard? During the financial year 2001-02 the central and state governments combined incurred a public health expenditure of Rs. 204 billion, this is expected to cross Rs 220 billion in 2002-03. This is barely 1 per cent of GDP. The health sector as a whole is worth a lot more as private health care accounts for four-fifths of health spending in the country. In real terms the health sector is worth Rs. 1000 billion or about 5 per cent of the GDP.

[5] It is indeed interesting to note that the Government has set ambitious targets even though the reach of primary health care facilities is far from satisfactory and we are nowhere near universalisation. With respect to maternal and infant mortality, the Tenth Plan avoids mentioning the current rate, but sets targets for MMR of 20 per 1000 live births by 2007 and 10 by 2012. Similarly it sets a target for IMR of 45 per 1000 live birth by 2007 and 28 by 2012. The Approach Paper to the X Plan is more cautious with respect to education and set a target of 72 per cent literacy by 2007 – this is when the spread and the reach of primary schools is far better.

Table 1

Changing Pattern of Central Government Health Budgets, Rupees in Million

	1975–76	1980–81	1985–86	1991–92	1995–96	1999–00 (BE)
Central Health Budget	880	1,630	3,410	5,580	8,450	23,090
Percent capital expenditure	40	37	25	32	1.4	0.0
Grant in aid to states			5,770	8,260	16,760	26,910
Grants as ratio to Central health expenditure			1.67	1.48	1.98	1.16

Source: Finance Accounts of the Union Govt., Ministry of Finance, various years, GOI, New Delhi.

Healthcare provision is the responsibility of state governments, yet the central government is a major player. In the late 1970s and the first half of the 1980s, the central government supported a massive expansion of the rural health infrastructure through the Minimum Needs Programme. Since the 1990's, however, such support has declined. Apart from supporting medical care in Delhi and some union territories and promoting family planning in the rest of the country there has been little support for public health programmes. Programmes countering tuberculosis, international borrowing or aid increasingly funds AIDS/HIV, leprosy and blindness control. It is clear from Table 1 that the investment by the central government in the health sector is on the decline. Capital expenditures have disappeared and grants in aid to states, which largely supports preventive care programmes like the National Disease Control Programs, is also declining as a ratio within the central health budget.

While the central government has cut back expenditures, the question is whether the state governments have made up the loss by raising their expenditures in the health sector. The fiscal record of the state governments on urban healthcare is much worse than that of the central government. The state government's expenditures are mainly– on teaching hospitals, district hospitals and health administration and family planning in the rural areas. State government expenditure on medical care, part of which is absorbed by family planning projects, indicates a drastic decline. Capital expenditures, which were high in the 1970s and 1980s when the big rural infrastructure expansion took place under the Minimum Needs Programme (largely supported by the central government), also show a declining trend. Government of India (GOI) finance data reveals that health expenditures both by the centre and the states are very low, both as a proportion to total government expenditures as well as a proportion to the GDP (Table 2 and 3). Moreover, the real growth rates too are low or even negative for most years. When we look at the health services/infrastructure we find an increasing concentration in the private sector. This is not good for a country like India where over three-fourths of the population is living either on, or below, the level of subsistence.

Table 2

Ministry Of Health and Family Welfare Expenditures 1991-2000, Indian Rupees in Millions

Category	1990 –91	1991 –92	1992 –93	1993 –94	1994 –95	1995 –96	1996 –97	1997 –98	1998 –99 RE	1999 –00 BE
All India Health expenditure at current million Rupees										
Total	50,780	56,390	64,640	75,180	82,170	101,650	113,130	126,270	163,030	178,540
Central	4930	5580	7050	7440	10680	12100	13460	13540	19070	23090
State	45850	50810	57590	67740	71490	89550	99670	112730	143960	155450
Health exp at 1981-82 Rs. In crores	27,750	27,110	28,220	30,310	29,880	34,340	35,910	38,260	46,310	48,910
Real Growth Rate of health Expenditure%		-2.3	4.1	7.4	-1.4	14.9	4.6	6.5	21	5.6
Share of state govt. in total Health exp.%	90.3	90.1	89.1	90.1	87.0	88.1	88.1	89.3	88.3	87.1
Grant in Aid component from Centre in state Health expenditure%	17.0	16.2	18.9	20.7	18.8	14.8	14.1	15.6	16.1	
Health exp. to total govt exp. In percent	2.88	3.11	2.88	2.91	2.13	2.98	2.94	2.7	2.9	3.0
Health expenditure as% of GDP	0.94	0.91	0.91	0.93	0.85	0.91	0.88	0.81	0.86	0.87
Per capita health exp. in Rupees/year	60.02	65.34	73.45	83.90	89.9	109.07	119.08	130.3	165.0	177.3

Source: Budget Papers of the Union Government; the RBI Bulletin (various years).

Declining expenditures have had an adverse influence on public health services. What has aggravated this situation further is allocative inefficiencies. Prior to 1996, salaries were already a very high component of public health spending, varying between 50 per cent and 75 per cent for different health programmes. After the 5th Pay Commission's award of new salary scales, the situation has changed dramatically with 75 per cent to 90 per cent of available resources under various health programmes going towards salaries. National survey data (NSS 42nd and 52nd Rounds and NFHS-1 and NFHS-2) reveals that the number of users of public health services have come down substantially during this period of declining expenditures and inputs into the public health system. This is especially true for medical care, both outpatient and in-patient care. However, this data also reveals that for preventive and promotive services like immunisation (children and mothers), antenatal care (women), and contraception (women) the public sector continues to be the main provider. This moving away of users, particularly the poor, from the public health system is building up a healthcare crisis within the country. Many of them can no longer afford private healthcare and hence neglect their health until it reaches a catastrophic point.

With the new health policy presently under discussion, this is an opportune moment to highlight and analyse this crisis and look at alternatives, which could help the public health system come out of this crisis.

Table 3

Public and Private Health Expenditure 1951–2000 (Rs. Billion)

	1951	1961	1971	1981	1991	1995	1996	1997	1998	2000
Public	0.22	1.08	3.35	12.86	50.78	82.17	101.65	113.13	126.27	178.00
Private: CSO estimate	1.05	2.05	6.18	29.70	82.61	279.00	329.00	373.00	459.00	833.00

Source: Public = Finance Accounts of Central and State Govt., various years; Private = National Accounts Statistics, CSO, GOI, various years and 51st NSS Round

The deteriorating overall fiscal situation of both the Central Government and the States has been highlighted in the Approach Paper to the 10th Plan: "The combined balance of current revenues of the Centre and the States declined from a negative Rs.133, 240 million in 1996-97 or 1 per cent of GDP to negative Rs.929, 690 million or 4.8 per cent of GDP in 1999-2000." (Paragraph 2.6) "The deterioration in the state finances in recent years is, largely, an outcome of the fact that in the face of a limited resource-base the States had to cope with a significant growth in their committed expenditure. These include wages and salaries, pensions and interest payments, which account for a major proportion of the non-plan expenditure and together absorb a sizeable part of the revenue receipts. The pension liabilities of fourteen major states have increased by 200 times from Rs.100 crore (1000 million) in 1975-76 to Rs.20, 000 crores (200,000 million) in 1998-99. It has, thus, increased from just 2 per cent of revenue receipts in 1980-81 to about 12 per cent in 1999-2000 and is likely to touch 20 per cent by the end of the Tenth Plan" (Paragraph 2.7).

Linking the fiscal situation to the need to mobilise external aid for the social sectors, the Tenth Plan document points out: "An important channel for mobilising resources for development, particularly for social sectors, namely the Externally Aided Projects (EAP) and direct funding of projects (i.e. outside budgetary flows) by the NGOs has not been sufficiently integrated with our planning process. Consequently, an important source of scarce resource for development, in the third world context, is not being adequately tapped" (Para 2.15).

Essentially the document argues for increased mobilisation of external resources for the social sectors. It attempts to bring about synergy between government spending and non-governmental initiatives – forcefully arguing for mutually beneficial partnerships.

3.4 NGOs and the private sector:

The NGO sector encompasses a wide range of organisations and can be broadly categorised as follows:

- *Development oriented organisations:* these organisations work among the poor, with the objective of enabling women and men to participate in development processes. There are also those involved in mobilising people to demand services and information; implement specific projects and programmes through grants from the government or donor agencies.
- *Social action groups:* These NGOs have emerged as part of the different people's movement with a focus on advocacy and mobilisation, organising and networking towards changing laws, policies and development programmes.
- *Resource groups, training organisations, and research/development planning organisations:* These groups generate and disseminate information and research, build national and global networks and provide professional consulting services in the development sector.

For almost a decade now, a number of established organisations have been functioning as Mother Units to channel government funds to smaller organisations. In addition, a wide range of service delivery organisations, charitable hospitals and medical practitioners have been supported under grant-in-aid schemes of the government and under the aegis of Standing Committee on Voluntary Action [SCOVA].

The RCH programme emphasised the role of NGOs and the private sector in "advocacy, counselling, raising community demand for RCH services and improving service delivery through innovative approaches that are complimentary to government services."[6] 650 field NGOs were supported through 57 Mother NGOs in 330 districts across 22 states. We still have little evidence on the impact of these programmes and therefore are not in a position to assess effectiveness of this strategy. However, a recent review of the programme (November 2000) recommended that NGOs could play a crucial role in 'medium and low-performance states' in augmenting the pool of trained paramedical workers – given that availability and accessibility of skilled midwives continues to be *the* most important barrier to safe motherhood.

In the last three decades there has been an appreciable growth in the NGO sector, partly because national and international foundations and bilateral donors have come forward with financial support. Many of them have done path-breaking work in the area of public health, women's health and community based programmes. While the government has acknowledged the importance of community participation in the health sector and has even supported NGOs and community-based groups, the public health system has not been able to introduce these strategies.

In addition to the above, a number of networks exist with specific agenda/ objectives, to name a few: HealthWatch, Medico Friends Circle, Voluntary Health Association of India, the Women and Health Network. These networks, apart from providing a forum for their associates to interact and keep in touch, are engaged mainly in public education/awareness and advocacy projects. In some cases their specific issue based campaigns have led to policy changes – the most notable ones in the last five years being the removal of family planning targets and most recently the National Population Policy (2000) and the amendments to the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act of 1994. The public interest litigation filed by CEHAT, a research and advocacy NGO based in Mumbai and Masum based in Pune, led to a landmark judgement by the Supreme Court on effective implementation of the PNDT Act.

The private sector includes a large proportion of individual private practitioners providing mostly primary level curative services of extremely variable quality. These practitioners are located in urban and rural areas in the country. The next level of care is provided by the private nursing homes with bed strengths ranging from 5 to over 100 beds. While in most states they are largely an urban phenomenon, where private sector growth (relative to public sector) is high, they have also spread to periurban and rural areas. Most of these nursing homes offer general and maternity services and are managed by doctor entrepreneurs. Within this category, there is a further division between small and large nursing homes, which differ widely in terms of investments, equipment and facilities, range of services offered and quality of care. In fact it is difficult to judge how many of them are capable of providing secondary level care of a reasonable standard. For example, in Delhi, only around 26 per cent of the nursing homes met the standards stipulated by the Delhi Nursing Homes Act. The large majority, therefore, are not in a position to comply with even the minimum care standards stipulated.

Private sector institutions providing tertiary care constitute roughly 1-2 per cent of the total number of medical care institutions. They are mainly the large hospitals run by trusts and private or public limited

[6] Aide Memoire: World Bank Mid-Term Review Mission of the RCH Programme, November 2000

enterprises. These are only an urban phenomenon and have been the largest beneficiaries of subsidies given by the government. Their interests are at variance with owners of nursing homes whose scale and nature of operation is much smaller. Given these differences it is important that the state pursue a differential policy towards the two segments.

Primary level care: The available studies on private sector health care in India suggest that a considerable section of the population in both rural and urban areas access the services of individual private practitioners for primary level care. Micro-level studies show that the poor from both rural and urban areas use these practitioners as a first resort for acute conditions, though they also use government facilities. There is much heterogeneity among providers in terms of qualifications, systems of medicine, and practices. They include herbalists, indigenous and folk practitioners, compounders and others. These practitioners, being easily available and accessible locally, are utilised extensively. Studies conducted in urban slums and rural belts indicate that the better-off groups in these areas use private practitioners but the really poor are unable to afford the charges and hence, either opt for government hospitals or often go without care. For the large majority of people particularly in rural areas, these health care providers are the main source for curative care. There is now a strong case, even if a second best one, for a purposeful initiative to train and upgrade their skills, since there is little prospect of their being replaced in the foreseeable future by qualified government or private doctors.

Secondary level care: A few studies on the secondary level of care show that it consists of institutions that provide both outpatient and in-patient services ranging from 5 to over 100 beds. These studies provide insight into the heterogeneity of these institutions in terms of the scale of operation, services offered, technology employed, and the social background of patients using these facilities. These studies have shown that there is variability in the quality and costs of services provided by these institutions. As a result there are no standards for these nursing homes and the consumer has no information regarding the costs he or she is likely to incur while seeking health care. Given these trends, it is essential that nursing homes be required to follow procedures for providing information regarding facilities available, the rates of the services provided, maintain patient records, and ensure access to them, and also build in the provision for medical auditing.

The heterogeneity of nursing homes and hospitals at the secondary level results in a conflict of interests between the smaller and larger players in the market. In some cases the contradictions are so sharp that it leads to divisions within the professional organisation and, in extreme cases, to the formation of separate fora like the Private Nursing Homes Association in Andhra Pradesh or the Nursing Homes Association in Delhi. Even where there are legal provisions available for registering nursing homes, these conflicts often cripple their implementation. In some instances the government tried to initiate a regulatory process by distinguishing between the smaller and larger enterprises (Andhra Pradesh and Delhi). While some progress was made, the owners of small nursing homes have formed a powerful lobby and have tried to slow down, if not reverse, the process.

The tertiary level of care consists of hospitals that offer a range of specialist services promoted by business groups, which are private or public limited enterprises, as trusts. These are located in metros and larger cities in the country. Since the late 1980s the promoters of many of these enterprises have strong non-resident Indian links and have influenced state policy on subsidies to this sector. Most of the subsidies offered by the government by way of land at concessional rates, granting medical care the status of an industry, and reduction of import duties on high technology equipment, have largely benefited these hospitals. During the 2002 budget debate, the promoters of these hospitals demanded an increase in subsidies. While these large private hospitals have been demanding more subsidies and concessions from the government, many of them were found to be flouting conditions prescribed by the government when duty exemption for import of medical equipment was granted. An important conditionality was that 20

percent of in-patients and 40 percent of outpatients should be from among the poor and that they should be treated free of any charges. The irony is that while they demand the status of an industry for financial support, they simultaneously want to retain the privileges of a welfare institution. *The Health Sector Reforms debate is yet to address this important issue in any comprehensive way.*

3.5 Donor support

In the post-ICPD Cairo period the World Bank, alongside UNFPA, UNICEF, European Commission, USAID and DFID emerged as key players in setting the RCH agenda in the country, even as WHO and DANIDA focused on communicable diseases. World Bank's involvement in health sector reforms (HSR) has been through a range of State Health Systems Projects – investing Rs 34,195.70 million in Andhra Pradesh, Karnataka, West Bengal, Punjab, Orissa and Maharashtra. Sida's role has been quite critical in interventions in the area of safe motherhood where it has worked through UNICEF in India. The European Commission has – since 1997 – focused on sector reforms in health. Their experience in negotiating an open-ended programme (and not an area specific, issue specific project) is indeed noteworthy. Given the favourable global environment in the post-ICPD era the total outlay for the RCH programme was Indian Rupees 51,125.30 million (RCH national initiatives Indian Rupees 45,650.30 million; 24 district projects in 17 states at Indian Rupees 2,828.80 million). This included an estimated US$ 250 million as loan from IDA/World Bank (see table below). In addition KfW of Germany has pledged DM 65 million and JICA (Japan) Yen 2061 million. In all the total foreign assistance for the RCH initiative in the Ninth Plan period comes to US$ 975 million.

Agency-wise commitment during the Ninth Five Year Plan period to Reproductive Health 1997-2002 (Rupees in million)

	IDA	UNICEF	UNFPA	GOI/EC[7]	DANIDA	DFID	Total
RCH	17889.36	5475.064	1825.000	24835.96	330.00	770.00	51125.325

As seen in the table above the World Bank (IDA) is by far the biggest player among external multilateral agencies in health and family welfare. The Bank's investment in health sector reforms is significant. Despite the fact that all World Bank investment is in the form of long-term soft loans, it continues to play a key role in shaping the content and direction of central sector schemes of the MOHFW and exerts considerable influence on Indian government policy.

Sida is one of the more modest players in the health sector, however, notwithstanding the quantum of funds, it could play a key role in demonstrating the viability and effectiveness of community based, gender sensitive and pro-poor strategies in the health sector.

[7] Includes EC and Counterpart – i.e. GOI contribution

4 Literacy and Education

4.1 Poverty, education and development

The importance of literacy and basic education in contributing to poverty removal and ensuring progress towards sustainable development hardly needs reiterating. Education lies at the heart of development and is central to the achievement of greater social and gender equality. Above all, it empowers individuals and communities, equipping them to take part in the modern economy and society. As Dreze and Sen (2002) have convincingly argued, more than the growth of income, it is the expansion of human capability, which needs to be seen as a central feature of the process of development. Obversely, poverty is ultimately a matter of capability deprivation affecting the freedom to lead normal spans of life or to read and write. Policies thus need to be assessed not only in terms of their ability to enhance economic growth and per capita incomes but also in their contribution to the enhancement of human capabilities.

As early as 1909, Gopal Krishna Gokhale, an early nationalist leader, had introduced a pioneering Elementary Education Bill for compulsory education. It was rejected by the colonial administration. It is thus heartening that the new millennium has seen the approval of the 93rd Constitutional Amendment Bill by the Lok Sabha, a significant move for giving legal teeth to Article 45, Directive Principles of State Policy which states "The state shall endeavour to provide, within a period of ten years from the commencement of the Constitution, free and compulsory education for all children until they complete the age of fourteen years."

4.2 Issues, concerns and trends

The provisional tables generated by the 2001 Census reveal that despite a host of schemes and programmes, only 65.38 per cent of the Indian people (75.85 per cent men and 54.16 per cent women) are today literate. A staggering number of children, close to 38.41 per cent of boys and 51.88 per cent of girls in the age group 6-14 are not attending school. Of these, the estimates of working children range from 11.29 million – 9.08 million classified as main workers and 2.2 million as marginal workers (GOI, Census 1991) – to 23 million (ILO, 1991). In addition 7 million children are estimated to be involved in household work, 88 per cent of them girls. According to the most recent data available from the National Family Health Survey (NFHS-2) conducted during 1998-99, 70 per cent of the youth aged 15-29 were reported to be literate (i.e., those born as recently as between 1970 and 1984.) While 83 per cent of young men were literate, the figure among young women was only 59 per cent. In rural areas, only about half of the women aged 15-29 were reported to be literate. While education department statistics (Selected Education Statistics, GOI, 2001) claim that 99 per cent boys and 82 per cent girls, aged 6-10 are enrolled in schools, NSS, GOI (52 Round 1995-96) reported the enrolment rate to be 80 per cent among boys and 68 per cent among girls. Of course, this data hides major disparities across region, rural-urban, caste, class, tribe and ethnicity. Vast regional differences are hidden behind national statistics/data. For example, there is convincing evidence to show that the belt comprising Rajasthan, Bihar, Jharkhand, Orissa, Uttar Pradesh and parts of Madhya Pradesh need special attention. Similarly some of the North Eastern states like Arunachal Pradesh, Meghalaya, Nagaland and Assam have long been neglected.

Table 1

Crude Literacy Rates by Sex and Residence, India, 1981-2001 *Males* *Females*

Year	Source	Rural	Urban	All Areas	Rural	Urban	All Areas
1981	Census (all ages)	49.6	76.7	56.4	21.7	56.3	29.7
1987-88	NSS	48.4	72.3	-	25.9	55.9	-
1991	Census (all ages)	57.8	81.1	64.1	30.6	64.1	39.3
1992-93	NFHS-1	62.9	84.1	68.8	34.5	67.5	43.3
1993-94	NSS	63.7	85.3	74.5	36.6	68.7	52.7
1998-99	NFHS-2	69.5	87.5	74.5	43.7	72.2	51.4
2001	Census (all ages)	-	-	64.1	-	-	45.8
2001	Census (7+ age)	-	-	76.0	-	-	52.9

Source: Census 1981, 1991, 2001; NSSO 43rd, 50th Rounds, and NFHS I and II.

Nevertheless, significant achievements have been recorded with a decadal jump (1991-2001) of 13.17 per cent for men and 14.87 per cent for women – and for the first time, a decrease in the absolute number of illiterates. Further, the importance of five to eight years of schooling for all children has come to be accepted as a societal non-negotiable.

The processes initiated in the 1980s in the wake of the national policy on education (1986) have been given a further impetus by specific initiatives like the Shiksha Karmi Project (Sida assisted 1987-1999, DFID 2000 onwards) and the Lok Jumbish Project (Sida assisted 1992-1999, DFID 2000 onwards) in Rajasthan, Bihar Education Project (UNICEF assisted, 1991), the Andhra Pradesh Primary Education Project (DFID, 1987), Mahila Samakhya (Dutch assisted, 1989) and more recently, the indigenously designed Education Guarantee Scheme of the Madhya Pradesh government. National efforts like the District Primary Education Programme (DPEP, 1994) and most recently the Sarva Shiksha Abhiyan have built upon and developed earlier basic education projects. Each of these interventions has underlined the importance of both context specific and multiple strategies to attack deep-set rigidities in the system. In addition to state effort and foreign donor funding, the recent years have also seen involvement (though small) of the Indian corporate community in providing both resources and managerial inputs. Besides this, we now have an institutional setting for the greater involvement of local communities in matters of schooling since the Indian Parliament's 73rd and 74th (Panchayati Raj and Nagar Palika Acts) Constitutional Amendments were passed, bringing in a third tier of governance.

Finally there has been the role of international agreements (Jomtien, 1990; Dakar, 2000) in pushing policy and the political elite into giving greater regard to constitutional imperatives. It was widely recognised by the international community that Education for All as pledged at Jomtien couldn't be achieved without eliminating the gender gap in basic education. This would require special attention towards programmes designed to improve participation of girls and women in basic education. It is now universally accepted that the current decade will be crucial, for if once again we miss the bus, it may be too late.

The Approach Paper to the Tenth Plan (2002-2007) points out that: "Out of approximately 200 million children in the age group 6-14 years, only 120 million are in schools and net attendance in the primary level is only 66 per cent of enrolment." Of the 80 million children in the 6-14 age group who are either out-of-school or enrolled but not attending school, about 60 per cent are girls. Of the 121.3 million adult illiterates in the age group 15-35, 62 per cent are women.

This situation exists despite a steady increase in enrolment, a fall in the percentage of never enrolled in school children and an exponential growth of private (recognised and unrecognised) schools in urban and rural areas. The number of primary schools in the country has increased over four fold – from 0.23 million (1950-51) to 0.93 million (1998-99) and enrolment in the primary cycle has gone up six times

from 19.2 million to 110 million. At the upper primary stage, the increase in enrolment is by a factor of 13 for all children and 32 for girls. The gross enrolment ratio at the primary stages often exceeds 100 per cent (this phenomenon is fairly common in India because children below and above the 6-14 age group enrol in primary classes), though the net enrolment ratio is about 20 per cent lower (Selected Educational Statistics 1999-2000, GOI).

The problem of access has been addressed to a significant degree with close to 90 per cent children in the 6-11 age group currently enrolled in primary schools (formal, EGS/Alternative Schools and private schools). There are today 2.9 million teachers in 760,000 elementary (primary + upper primary) schools. While the National Family Health Survey (1998-99) reports a significant increase in 6-14 age children attending school (73.7 per cent girls, 83.1 per cent boys), it also reveals that *only* 34.2 per cent girls and 53.3 per cent boys (of all those who responded to the survey) complete primary education. The median number of years of schooling is 5.5 for boys and 1.8 of girls and only 35.6 per cent boys and 19.7 per cent girls' complete middle school. Further, regional variations are pronounced, with discernible differences between the educationally forward and the not so privileged areas.

While the overall completion rate of the full primary education cycle (completing class 5 in some states and completing class 4 in others) is 78 per cent in Karnataka, 62 per cent in Maharashtra and 55 per cent in Tamil Nadu, the figure dips to under 40 per cent in Uttar Pradesh, Bihar, Orissa and Madhya Pradesh. However DPEP reports of 2000 and 2001 report an overall 29 per cent drop out rate in all its districts, with over a quarter of the districts experiencing drop out rates as high as 40 per cent. (Yash Agarwal 2000 and 2001)

To reiterate, while continuing to stress the importance of access to schooling, an equally significant problem is retention/dropout and the number of years taken to complete schooling. Within this broad picture, the situation is worse for the rural and urban poor and the socially disadvantaged groups, scheduled castes and scheduled tribes (SCs/STs). Within each category the situation of girls is worse than that of boys.

Equity: It is undeniable that there has been a significant increase in overall literacy and school participation rates. Equally significant is the decline in the proportion of children never enrolled in schools and gender and social disparities that result from increased attendance. Nevertheless, the gaps remain significant. The NSS (52nd round, 1995-96) estimates that "31 per cent children in the age group 6-11 were not attending school (and) availability of schooling facility even within the habitation does not offer any guarantee that all children in the eligible age groups attend school." And that literacy rate variation across the spectrum and between gender and caste groups is correlated and higher overall literacy goes with lower disparities. *The more educationally backward a region, the greater are the social and gender inequalities.*

Disaggregated data on out-of-school children who have never enrolled in schools, reveal a disproportionate presence of special groups like working children, those in urban slums, residents of far flung habitations, SCs/STs and nomadic groups. Within all these categories the proportion of girls is high. A new trend, less recognised, is the coexistence of a multiplicity of schools – government primary school, EGS, alternative and private (recognised & unrecognised). *Recent research reveals the emergence of a new stratification, a hierarchy of access.* The trend indicates that the less well off, usually girls and the socially marginalized are clustered in specific types of schools, often EGS, alternative and government primary schools, with the better off, upper caste boys steadily shifting to private schools. *This process has significant implications for both social policy and negative social stratification. We are thus facing a paradoxical situation that alongside a further democratisation of education, mainly through the expansion of EGS schools (through the government), we may more deeply be inscribing NEGATIV social markers on children.*

The rapid growth of EGS schools or Shiksha Karmi schools has revived the old debate of dualism in education, a process further exacerbated by the proliferation of private schools. At one level, financial constraints are impeding an expansion in formal government schools or the hiring of teachers. The new '*para-schools*' at least provide some schooling. Simultaneously they seem to be relegating precisely those sections that require the maximum attention and resources to a 'second tier of education'.

Quality: For a long time, poor performance on the basic schooling front was attributed to a lack of schools and teachers on the supply side, and poverty, parental attitudes, social barriers and prevalent social customs on the demand side. As noted earlier, significant progress has been made on both fronts. Recent research, however, indicates that an important factor, if not more important than the above, in explaining both the high dropout rates and also the persistence of out-of-school children, is the stark fact that many of our schools are unattractive- physically and pedagogically. Unless adequate attention is given to the software of education and issues of quality, it is unlikely that we will be able to attract children, retain them in school, and above all ensure that they have access to a meaningfully learning experience.

As against the universally recommended norm of 1:30 as a teacher-student ratio, many schools, particularly in educationally backward areas, have a ratio as high as 1:70 (DPEP, 14th JRM Aide Memoir, 2001). In addition, we have the perennial problem of single teacher schools, multi-grade classrooms, inadequate and poor quality teaching-learning material, and so on. Equally deplorable, despite recent efforts, is the state of teacher training and issues related to cadre management. Finally, few schools have made any serious effort at involving students, teachers and the local community in managing the school environment. Of course, at a broader/systemic level, attention has to be given to institutional development, monitoring, evaluation and research and political decisions about teacher accountability.

We need to recognise that there are no short cuts to quality improvement. But if the focus has to shift from enrolment to retention and completion of the full elementary education cycle, learning outcomes have to be privileged over mere attendance. Equally, unlike in the past, quality interventions cannot be piece-meal and will have to simultaneously influence all the dimensions – teacher education and development, curriculum and pedagogy, classroom environment, child-centred processes, assessment practices and the overall school environment.

Forward linkages: Once children start school, a range of factors determine whether they will continue or drop out, whether and how much they learn and whether they acquire the skill/interest to pursue further education. If and when children do drop out due to poverty, migration, other economic factors, rigid gender roles etc., the presence or absence of programmes that enable them to get back into the formal system determines whether they can re-enrol in the school system.

Even if most children are able to avail of 10 or 12 years of schooling, the presence or absence of institutions of higher education (including vocational training) determines access. While government subsidy for technical and higher education has significantly decreased in the last five years the number of good quality institutions are few and far between. Given the primary focus of this document, it cannot do justice to the complexities and range of issues in higher and technical education.

Experience has shown that the presence of a group of demoralised/disillusioned youngsters, who may have completed primary school or dropped out, acts as a disincentive for other younger children in the family/community. This is particularly true if the education imparted does not lead to any material gain (employment/self-employment), or even the unquantifiable value addition in terms of social capital. Increasing adolescent crime and social unrest among 'literate' youth further reinforces negative attitudes towards both the youth and education (Planning Commission Working Group on Adolescents, GOI, 2001).

It is now universally recognised that in order to revitalise basic education, it is essential that we need to focus on the following:

- Move from 'access only' to 'access to good quality education'.
- Move from primary to upper primary, middle and high school and forward linkages to higher and technical (including vocational) education.
- Create multiple exit points after class VIII through vocational education, skill and livelihood training alongside opportunities for out-of-school children to improve their educational level through accelerated learning programmes.

Special focus groups: Despite all efforts at enrolling and retaining children in the age group 6-14 in school, we have seen that a range of social groups present specific challenges and constitute the majority of out-of-school children. Notable among these are child workers, special needs children and adolescent girls. Child labour, in particular, has been the focus of much attention. It has often been argued that children remain out-of-school because their families need the income from their labour. Equally, that their presence at home, especially in the case of girls, frees parents and older siblings for the job market. Contrary to this perception, recent studies of the time utilisation of children reveal that a large majority of out-of-school children are not engaged in full-time work. Many are neither in school nor active members of the workforce.

Even when they do work, the direction of causation need not run from child labour to non-attendance. Often, it is those children who are excluded from school who take up work as a default occupation. Moreover, even when the child's income is essential for the family, the time spent in these activities is small. There is also some flexibility of work hours. Finally, it is also argued that most working children are those who have never been to school. However, recent studies show that many children who attend school work both before and after school hours. Therefore drawing a one-to-one causality between work and non-enrolment in school could hide context specific nuances of this very serious issue.

Unfortunately, data on special needs children – physically and mentally challenged – remains scanty, notwithstanding some pioneering work done in select DPEP districts in the last three years where an effort was made to set up special schools and integrate these children in general schools. An educational environment remiss at handling 'normal' children has a long way to go before it can be expected to respond satisfactorily to the needs of handicapped children with deprivations.

Finally, mention must be made of the problems of adolescent children in the 11- 17 age group. The NFHS-2 (1998) reveals that less than a third of these children are in school. Of those who have dropped out, for girls marriage is usually the reason, less than half have minimum literacy skills. More disturbing is the conventional media portrayal of adolescent boys as violent, troublemakers, sexually active, vulnerable to drugs and infected with HIV/AIDS! Even though the Planning Commission acknowledges the need to focus on the education and development needs of adolescent boys and girls, and in fact it calls them "*a tremendous force for change and reconstruction, yearning to be involved in work and development*", the grim reality is that the needs and aspirations of adolescents are ignored. There are no programmes addressing issues of health, education, sexuality, employment and livelihood, skill and leadership development in a holistic manner within the broad frame of human rights and democracy (Planning Commission Working Group on Adolescents, GOI, 2001).

4.3 Government policy, the reform agenda and budget allocations:

Unlike the health sector where there have been significant improvements in certain health indicators as detailed earlier in 'Government policy and budget allocations' in Section 3 (Health and Nutrition) of this document– there is no 'formal' reform programme that is underway at the moment in education. Most systemic issues were addressed in the National Policy on Education (1986) and Programme of Action (1986 and 1992). One of the major initiatives, namely the DPEP, brought centre stage a range of reform issues. More recently, the 93rd Constitutional Amendment Bill (passed by the Lower House of parliament on 28 November 2001) attempts to give policy level commitments more teeth. The Sarva Shiksha Abhiyan programme of the GOI has tried to encompass supply and demand side issues. Therefore the 'reform agenda', as reflected in key government initiatives has tried to take on board two givens.

– One, at the formal political and policy-making levels there is unanimity about meeting the long delayed constitutional objective of ensuring education for all.

– Two, there is no dearth of analysis of factors – physical, socio-cultural, fiscal – responsible for the state of affairs nor any shortage of schemes to address designated problems.

Responsibility for education is concurrently shared not only by the national and state governments but also, particularly since the 73rd and 74th amendments, by locally elected bodies at the district, block and village levels. Moreover, recent programmes have introduced new structures in the form of village education committees (VECs), parent teacher associations (PTAs), school betterment and management committees (SBMCs) and the like to ensure greater community participation. The resultant system is not only complex, it poses serious challenges to administration. A multitude of authorities with overlapping agendas might create potential problems in pinpointing accountability and responsibility. These issues come to the fore when deciding questions related to the establishment of new schools, hiring of teachers, decisions about salaries, working conditions etc.

Despite formal acceptance of decentralisation, control, especially of funds, remains highly centralised. In most states, planning is still based on uniform district project expenditure and local bodies have neither the funds nor the power to evolve and implement their own plans. At the teaching level, not just control of teachers but academic norms relating to content and pedagogy are decided at state if not national levels.

The question to address is the lack of progress in educational systems reform. This too, in a scenario where there is agreement on both the need for education reform and the strategic choices necessary.

One school of thought regards education as a fundamental basic right and locates the problem in the failure of the Indian State. It is argued that unless the state dramatically increases the investment in education to at least 6 per cent of GDP, no major changes are possible. Further, that this is a feasible target, requiring an incremental investment of 0.7 to 1 per cent of GDP to be earmarked for basic education per year. Finally, that only the state is in a position to provide enough schools, teachers and teaching aids, while civil society should generate the necessary political pressure for the state to perform its duty.

This strain of argument, however, shifts the terrain of discussion into the realm of public finance. The harsh reality is that without major reallocation of public resources, it is unlikely that the Indian State will be able to release the needed resources for education. The imposition of an education cess, reallocation across sectors or even within education to favour elementary education requires political will. This is a doubtful outcome. The resource crunch becomes more severe the lower we go down the hierarchy – from the Centre to the states and local bodies. It appears that fiscal constraints are most severe in the regions of greatest need.

A greater problem with supply side arguments is that they pay insufficient attention to the efficiency of resource use, that even if there are more schools and teachers, children may still remain out-of-school and not learn. This is both because of problems in society and within the school system of poor infrastructure, teacher absenteeism, quality of teaching, pedagogy and textbooks.

Does the answer lie in decentralisation and community involvement? In the last decade, the state has sought to shift the responsibility for poorly or non-functioning schools to the community. The paradox is that while the community is invited to participate in cost sharing (space for schools, maintenance and upkeep, teaching aids, even meeting teacher salaries), there is extreme reluctance to actually relegate control and ownership to the community, or even to formal bodies like the panchayat. The pressure comes partly from the teaching community, which does not want to be accountable locally, or give up career advance opportunities available to a state cadre. More important are issues of ideological control of teachers, textbook and pedagogy, which fall into the realm of political decisions.

Within this framework, external actors – donors or NGOs – are permitted a minor and supplementary role. Even if invited in for resource supplementing reasons, uncertainty remains, since such assistance is usually time bound. The local governments are apprehensive at the possibility of being stuck with schools, teachers or activities that they cannot sustain.

A second stream of argument, while granting the primacy of the state in the provisioning of basic education, shifts focus to what is contextually doable by seeking to transform both the content and delivery of basic education. Working primarily through non-formal education centres, alternative and education guarantee schools, sometimes collaborating with regular government schools. Attention is directed to teacher training, textbooks and curricula, pedagogy, monitoring and evaluation systems etc. Greater emphasis is given to involving the community through both formal and informal mechanisms and focusing on those most in need – out-of-school children, girls, scheduled caste/scheduled tribe (SC/ST)/minority groups, working children, street children etc. Many of the innovations – both quality improvement and cost reduction – fall into this camp.

There are two major criticisms of this approach. One that it side-steps macro societal and political questions, particularly those focusing on the responsibility of the state. There is insufficient appreciation of legal/constitutional/administrative mechanisms that would either pressure the state to perform or create an enabling environment for non-state actors to play a more meaningful role. The second is that the programmatic content of these strategies is piecemeal (concentration on solving a specific problem) and that it may legitimise structural dualism in education. As mentioned earlier, non-formal education, alternative schools and EGS Schools, whether aimed at standing alone or as transitory pathways to mainstreaming are seen as providing 'lower' quality, second best education. Of course, one can argue that the ideologically satisfying position of seeking the best, of insisting that everyone accesses the same quality of education, is a sure recipe for the poor not getting anything at all.

A workable strategy has to draw on both approaches – of introducing improvements where possible while continuing to pressure the state to both invest additional resources (on its own or with help from external/corporate donors) as also make necessary legal/institutional changes. More than at the national level, linkages need to be strengthened between local/state governments, NGOs, education experts and donors. To be a reality, there has to be the will to make basic education a social good and a movement, within which all sections of society own responsibility.

We now turn to a few specific areas:

a. Reforming public spending:

- Most states with the poorest educational indicators face serious problems with the structure and sustainability of their pattern of public funding. High achieving states have a higher per capita expenditure on elementary education than the rest. Even this low expenditure is distorted by an inordinately high share of teacher salaries (97 per cent) in total recurrent spending at the elementary level, leaving little resource for non-salary expenditure. Despite this, teacher absenteeism is high.

- The central government could attempt to equalise per capita spending on primary education across the states. Expenditure on a per capita basis, defined as a certain quantum per child, of the relevant age group, could be the basis for determining central grants to the states. Second, fiscal priority to elementary education needs to increase compared to outlays on secondary and higher education alongside efforts to institutionalise greater cost recovery at these levels.

- Since it is unlikely that states will have the resources to maintain non-salary expenditures at the same level post DPEP, grant-based external assistance could be earmarked for this expenditure. Fresh expansion could occur through EGS type schools. Induction of new teachers at full-scale salaries may continue to be limited (or even disallowed, given the fiscal situation of most states), fresh recruitment being confined to parateachers. Besides this, conversion of private unaided schools into aided ones could be frozen.

- Finally, there is a need to explore an education cess, earmarked for elementary education and the setting up of an Indian Education Fund.

b. Community involvement:

- The Indian experience demonstrates that wherever the voice of the people has been made more effective, most notably in Kerala and Madhya Pradesh, the results are impressive. Research on the functioning of PTA/VEC/school betterment committees, however, shows serious shortcomings. It is suggested that in addition to a VEC, there could be a PTA at each school, which must meet at least once a month, and regularly hold literacy mapping exercises to identify children not attending school or those who have dropped out. Financial assistance from the Centre to the states could be made conditional on putting these institutional mechanisms in place. Finally, to strengthen decentralisation, the authority for leave granting and salary release for all teachers in all states could be handed over to the panchayat.

c. Teachers:

- Regular fresh appointment of parateachers in both EGS and regular schools can reduce high pupil-teacher ratios, and address the problem of single teacher schools. Effort should be made to focus on hiring female teachers and changes made to encourage their application (quarters, employment of married couples). Another factor worth investigating is an increase in the number of teaching days.

- Exploring the possibility of creating a forum for women teachers, as was done in Lok Jumbish, could address a range of gender specific issues in teacher management.

- Major efforts are needed to strengthen teacher training, both before induction and during employment.

d. Non-teaching inputs:

- The cost-effectiveness of non-teaching inputs must improve. As recommended by the Supreme Court of India, the mid-day meal scheme could move towards providing cooked food, preferably with community involvement.

- Other incentives like uniforms, textbooks and scholarships, particularly for girls, could be introduced.

- Uniforms should be made optional. To reduce recurring costs, textbooks should be hard cover and kept in the school; scholarships should be directly paid into bank/post-office accounts in the joint name of mother and daughter to encourage gender equity. The effort has been to make the schemes transparent, less cumbersome and reduce the possibility of leakage to intermediaries.

e. Private-Public interface:

- It has repeatedly been stated that if UEE is to be achieved, the efficiency and equity of the entire system, not just of the public sector, has to improve. Here comes the role of the private sector. Research shows that there is no firm evidence of better learning achievements in private schools. Two, take-over of private schools by the state (conversion of unaided into aided schools) has negative equity implications. Third, despite exponential growth, private schools remain unregulated. Finally, the major competitive advantage of private schools is that they teach English.

- It is suggested that there be a national policy on private education, and all unrecognised schools be made to register and be regulated. A freeze should be placed on conversion of unaided to aided schools, and the latter should conform to strict performance criteria. Finally, mechanisms should be explored for encouraging private schools to hire teachers earmarked for teaching English in government schools.

The above are merely illustrative suggestions made by a number of researchers and practitioners. They focus attention on some of the most difficult issues related to making the system work and become more responsive to ground level situations.

Ensuring adequate facilities for all children under the age of 14, in or out-of-school and covering their costs of education requires considerable public resources. The Kothari Commission (1964) argument maintained that 6 per cent of GDP is the resource requirement necessary to meet the goals of UEE has been widely accepted. Yet, this target has never been met and currently (2001) is at 3.2 per cent. While this represents a substantial increase from 1950-51 (1.2 per cent), in terms of plan outlays, the proportion of expenditure on education has fluctuated – from 7.86 per cent in the First Plan to 4.50 per cent in the Eighth Plan (1992-97). The Ninth Plan, however, more than tripled the fund allocation to education. Equally, though in the past greater emphasis was accorded to secondary and higher including technical education, the Ninth Plan outlay stood at 65.7 per cent for elementary education. Out of the Ninth Plan allocations of RS 163,695.90 million for elementary education the expenditure stands at Rs. 142,255.80 million, with Rs. 40,557.10 million being external assistance (loan and aid).

More than the broad figures at the national level, we need to shift focus to the states, particularly educationally deprived states. Further, we need to correct the imbalance between plan and non-plan expenditures; a lower plan outlay cripples expansion plans. Finally, we need to give a hard look at the norms used to arrive at estimates – teacher salaries, type of school in which the additional enrolment is to take place, the public-private interface etc.

4.4 NGOs and civil society:

NGO involvement in elementary education has been quite substantial in India, especially in beating new paths and reaching children who are more difficult to reach. While this document does not purport to cover the history of NGO and civil society involvement in basic education, an attempt has been made to give a brief overview. NGOs have essentially been involved in non-formal education and in literacy campaigns and their work areas can broadly be categorised as follows:

- Pre-school education;
- Accelerated educational programmes for out-of-school children and youth. These programmes give older children an opportunity to complete primary education, and where possible, enable them to either get back into the formal system or help them acquire knowledge/skills, livelihood skills (skills for development), life skills through holistic educational programmes;
- Building self-esteem and self-confidence of children and youth from disadvantaged communities/ areas;
- Making school a joyful experience and infusing meaning into educational processes together with in-school remedial courses that enhance learning and reduce dropout rates.
- Social mobilisation specifically targeted towards working children;
- Social mobilisation under Total Literacy Campaigns;
- Educational resource support (curriculum development, teacher training, and participatory learning tools) to government and other NGOs programmes.

In the last ten years specific government programmes like the Shiksha Karmi Project, Lok Jumbish, Total Literacy Campaign and most recently the Jan Shala Programmes (a Join UN System Programme) and Education Guarantee Scheme have made special efforts to forge mutually supportive linkages with field based NGO. There is a wealth of experience of government-NGO collaboration, which indeed merits an independent study. Three broad trends are discernible, namely:

a) Some non-government organisations and women's groups worked closely with the government in designing programmes. This led to the development of many innovative programmes in the education sector – the most notable being the Shiksha Karmi Project.

b) Some non-government organisations and feminist groups distanced themselves from the government and focused on mass-mobilisation around issues that affect the poor, including literacy. The most notable among them is the Bharat Gyan Vigyan Samiti that played a pivotal role in the Total Literacy Campaign.

c) NGO-corporate-municipal corporation partnerships to revitalise the education system and reach out to out-of-school children. The most notable among them is the India Education Initiative – Pratham, working in over 12 cities across the country. In the same genre are NGOs involved with child workers with a focus on getting them out of work and into school like the M V Foundation, Hyderabad. Another example is The Concerned for Working Children, Bangalore, which attempts to improve the quality and relevance of education.

4.5 Donor interventions elementary education:

Almost all the major donors – bilateral and multilateral – have been supporting the Government of India's elementary education programme, the flagship project of which is the DPEP. While the World Bank is one of the key financiers (soft loan), the contribution of the European Commission and the DFID has been significant. In addition UNICEF and the Development Cooperation Division of the Royal Government of Netherlands have also contributed to specific components in the DPEP.

Table 2

Eighth Plan (1992-97) and Ninth Plan (1997-2002)Outlay and Actual Expenditure (*Rs in million*)

	Eighth Plan		Ninth Plan	
Name of Project	**Approved Outlay**	**Actual Expenditure**	**Approved Outlay**	**Actual Expenditure**
Rajasthan Shiksha Karmi (Sida and DFID)	350.00	294.10	319.10	727.90
Rajasthan Lok Jumbish (Sida and DFID)	900.00	639.30	721.60	1,962.60
Bihar Education Project (UNICEF)	1,180.00	589.60	-	-
Mahila Samakhya (Netherlands Government)	510.00	184.40	350.00	300.05
Uttar Pradesh Basic Education Project (World Bank)	10.00	2.00	-	-
South Orissa Project (Source not available)	50.00	2.00	-	-
DPEP (World Bank, DFID, Netherlands, European Commission and UNICEF)	2,300.00	5,129.90	36,420.00	37,466.10
GOI-UN Janshala Programme	-	-	0.00	100.0.00
Total	5300.00	6841.30	37,810.70	40,557.10

Source: Department of Elementary Education, Ministry of Human Resource Development, Government of India, 1999 and 2002 (expenditure up to 15 March 2002 only).

Negotiations are still underway with respect to donor support to Sarva Shiksha Abhiyan and the Tenth Five Year Plan, with the exception of the European Commission (which signed a financing agreement with the Government of India in November 2001). The details of EU support to SSA are still being worked out. The government has not yet taken a firm decision on the nature of external aid to SSA and may or may not continue with the DPEP model of several donors contributing to one project with joint review and monitoring systems. Therefore, Sida has ample scope for negotiation and can carve out a special niche, thereby making a significant contribution, albeit small, in the area of education and literacy.

Without for a moment denying the important role external aid has played in the provision of elementary education, it is still peripheral. Even DPEP, by far the largest of all externally assisted programmes, accounts for less than 3 per cent of the total government expenditure on elementary education. The more positive role of these programmes has been, not in resource supplementing, but in facilitating needed reforms. On the obverse side, it must be noted that these programmes create imbalances between chosen and non-chosen districts. *Further, in an overall environment of fiscal stringency, external fund availability sometimes weakens the impulse towards internal resource generation. Here is where we face the real danger of programme collapse once the aid cycle comes to an end.*

5 Challenges and Opportunities

5.1 Health and Nutrition:

Section 3 on Health and Nutrition summarises broad trends and issues that frame the ongoing debate in the sector. While the list of issues is long, an attempt has been made in this section to list some of the key challenges facing the country.

1. The overarching challenge faced by India is to improve the health and nutrition status of the poor, especially women. The country cannot hope to attain its development goals without giving this sector the attention it merits by systematically addressing issues of access, quality and financing.

- Linking health programmes to poverty alleviation is critical. This is particularly so because the burden of health services falls disproportionately on the poor. Besides this, the non-availability of financial resources remains one of the main reasons for untreated illness thereby resulting in a sharp increase in morbidity – especially over the last ten years. This burden is compounded further in a situation of unequal gender relations on the one hand and unequal social status on the other.

- Poverty, social justice and gender issues have not been brought centre-stage in health sector reforms (HSR) and there is little scope for active citizen involvement in priority setting. Unfortunately the piecemeal and sporadic approach has continued, resulting in separate/parallel activities in hospitals, drugs supply chains and to a lesser extent in other areas. *While a range of activities and projects are being 'justified' in the name of health sector reforms, there is no cohesive understanding as such of reforms.*

- The biggest challenge facing health sector reforms today is to approach the health delivery system from below and explore how services can reach the needy – thereby integrating gender and social equity issues into health sector reforms. While the government has made a good beginning by introducing the concept of Community Needs Assessment in the RCH programme, operationalising this approach has remained problematic.

2. The existing health delivery system is based on loosely integrated vertical programmes of reproductive and child health (under the Department of Family Welfare); control of communicable diseases like malaria, tuberculosis and a range of water-borne diseases and a stand-alone HIV/AIDS prevention programme (under the Department of Health). Effective convergence and ground level integration and synergy remains a big challenge.

3. Quality remains *the* biggest challenge to utilisation of public facilities.

- There is a wide consensus on the broad determinants of quality: adequate access and availability, routine and reliable information on the scope of services and what is available at which level. The latter includes the infrastructure and service environment; privacy and confidentiality; waiting time, inter-personal relationships and follow-up programmes. Despite this consensus, the experience of the last five years shows no significant change in service environment or availability or even in the infrastructure (Ninth Plan MTR, GOI, Planning Commission 2000). The bottom line is that there are no shortcuts and no quick-fix formulae, the problem of quality cannot be addressed at the micro level of a project. The entire health delivery system *has* to gear itself to quality.

- There has been a steady deterioration in the quality of care in the public sector, while at the same time there has been an exponential growth with little regulation of private sector activities in health. This has far reaching consequences for the health of poor women, children and old people. It is widely recognised that quality and cost of services in the public sector influences quality in the

private sector – the two are linked. Where the public sector is dysfunctional the private sector is equally bad and costs are high. Conversely, where the public sector is functioning and is of reasonable quality, cost and quality in the private sector is not as proportionately high.

4. There is little space for informed debate on our expectation from the public health system. Planners are yet to devise mechanisms to tackle issues of accountability of providers, rights and entitlement of people and dignity and respect for the poor, especially poor women. NGO experiences in the area of micro-planning and health-mapping are yet to be tried out in the public sector, this is not only a big challenge but could emerge as a unique opportunity in a district based RCH programme of the government.

5. The Auxiliary Nurse Midwife (ANM) continues to be the primary service provider and her responsibilities include immunisation, safe delivery (pre and postnatal check-up of pregnant women), community needs assessment, contraception motivation and distribution, survey of eligible couples and maintenance of CPR registers. Non-availability of skilled medical personnel, including nurse-midwives, remains *the* major bottleneck to universal access to the first level of health care.

5.2 Literacy and Education:

Section 4 on Literacy and Education identified a few key problem areas that continue to afflict the elementary education sector. The biggest challenge facing us today is to reach out to this hard to reach group with good quality education. We can no longer look at gender disparities in isolation – the intermeshing of geographic location, social status, economic position, gender, occupation and displacement/migration has resulted in new forms of disparities and disempowerment. Ensuring equal quality of access remains a big issue. Reaching out to the most deprived merits more resources, more human resource inputs and a great deal of commitment from the government and donors. Low cost options like EGS, AE are inadequate, they will merely accentuate existing social inequalities.

To recapitulate, some major challenges faced in this sector are as follows:

1. Prevailing hierarchies with different socio-economic groups having access to different kinds of schools. Multiplicity of types of schools – government, EGS, private (recognised and unrecognised) – has further reinforced existing social divisions in society. When taken together with the prevalence of a relative freeze in opening formal primary schools and recruitment of regular teachers on the one hand and exponential growth of EGS/AS schools and parateachers on the other the situation is indeed worrisome. Existing dualism in education supply and a stratification of school population by type of schools provided has serious implications for education policy.

2. While the issue of access has been successfully addressed in many areas of the country through the DPEP and other Education for All (EFA) projects, social and physical distance to schooling continues to be a problem. General household characteristics like income, caste, occupation and educational level of parents continue to determine access, attendance, completion and learning achievements. Children from rural families with substantial land, non-agricultural occupations and a higher educational level have greater access than children from landless, agricultural wage-earning families and migratory groups. Their invisibility in macro data has contributed to their alienation from the educational processes. Those most affected are:

- Severely disadvantaged communities and those residing in tribal, hilly, desert and remote habitations continue to have limited access.
- Girls, who are among the most deprived, their situation continues to be worrisome, with many dropping out at all levels.

– Child labour, which persists in many parts of the country and yet their numbers are invisible in data compilation of children working at home, especially girls.

3. Quality of education remains a big challenge leading to poor learning achievements and low relevance of the curricula.

– Low retention, attendance and completion of the primary education cycle alongside high dropout rates, especially among the poor and within this section, girls. This is also related to social marginalization arising out of caste/community prejudices.

– Uneven and high pupil-teacher ratios and a high proportion of multi-grade classrooms.

– Discouraging a teaching-learning environment, particularly for children who are first- generation learners. Inadequate teacher training and pedagogically questionable teaching practices.

4. Multiple and overlapping authorities at the helm and poor linkage between community organisations and formal authorities at the local level. This is despite a great deal of formal rhetoric in favour of decentralisation of participation.

5. Lack of appropriate disaggregated data by special focus groups, and, within each group by gender. There is also minimal data output resulting in ineffective monitoring of progress.

6. Forging forward linkages from primary to upper primary and further on to high school is important. Planning for one level and leaving the rest unattended would indeed be self-defeating.

While overall decline in access, infrastructure, functionality, quality and attitudes affect all children, given the prevailing social inequalities and hierarchies, these factors affect poor children and among them girls much more that they affect the more privileged sections of society. The privileged groups are increasingly opting out of government schools and moving to private aided and unaided schools. Even when they do use government schools, they have access to schools of far superior quality and have the resources to supplement the teaching provided with private tutoring.

There is a national consensus that the primary responsibility of basic education has to be shouldered by the government because it alone has the mandate, the ability and the wherewithal to respond to the educational needs of the poor – more so because it is usually the very poor who go to government schools. Enhancing their capabilities and providing them the tools to negotiate this unequal world from a position of strength requires political commitment and societal support. Investing in the development and growth of those who need it most is the need of the hour. DPEP has indeed made a beginning with respect to primary education; the question is whether this momentum will be sustained through SSA and at higher levels and for another decade. If it is, India may well be able to achieve the goal of Universal Elementary Education by the year 2010.

6 Possible future support

6.1 General considerations:

The preceding sections capture, in a nutshell, key issues and challenges in two important social sectors, health and education. An effort has been made to focus on issues that are of central importance to Sida, namely rights, social justice and gender equality. Obviously no one donor can hope to take on board the entire universe of issues and concerns. Given the limited resources that would be available, the recommendations made in this section have been based on the priority areas as identified by Sida and on past experiences in India's health and education sectors.

In the past Sida has worked in partnership with UNICEF (CSSM Programme). It is now suggested that Sida explore the possibility of partnering with other donors/multilateral agencies. Some possible avenues of partnership are suggested below – which are basically indicators and based on discussion with donor partners.

One important issue that could be taken on board and discussed with the government and also with donor partners is the importance of forging meaningful and workable linkages between the two sectors. It hardly needs to be emphasised that health outcomes and educational status are interrelated and lasting progress would not be possible unless they are seen as two sides of the same coin. This involves enhancing the capabilities of people and enabling them to make informed choices, negotiate from a position of strength and confidence and take control of their lives. This is especially true for women, whose ability to take decisions and gain control of their lives and their bodies, will not be possible unless education and literacy is brought centre stage.

6.2 Areas of cooperation:

As outlined in the Introduction, a human rights and social justice perspective needs to be the overarching framework in which social sector programmes work. This is a priority and Sida could focus on building the capacities of people to plan and set their own priorities. Working in a decentralised and participatory mode has been a corner stone of Sida policy for international co-operation. Drawing upon past co-operation, namely Shiksha Karmi and Lok Jumbish in Rajasthan and the proposed pilot initiatives in child survival and safe motherhood Medak (Andhra Pradesh) and Bidar (Karnataka) Districts; the most valuable input that Sida could bring into the social sectors is community participation and empowerment with a view to enable the people to interact with the system from a position of strength. *This is the special added value that Sida could bring to the arena.*

External assistance in India is almost invariably reflected in the planned allocations of the Government of India. Externally aided projects and programmes are, in most cases, approved as Central Sponsored Schemes or Central Sector Programmes. In the last few years there has been some debate on whether donor funds should be an addition to the GOI budget allocations or merely a substitution. This is a difficult question to answer. In the last ten years (8^{th} Plan and 9^{th} Plan) budget allocations were made for specific programmes and projects both on the basis of assured external funding and with purely domestic resources. For example, externally aided projects in the education sector in fact increased the GOI's budget between 1987 (when APPEP and Shiksha Karmi were started) and 2002 (by which time DPEP had expanded to 291 districts across the country). This did not, at least on the face of it; reduce the GOI allocations to other central sector schemes. On the other hand, the GOI enhanced investments in adult literacy purely through domestic resources and non-availability of external aid did not reduce financial allocations to adult education. As discussed in the sections above, external aid forms a very small propor-

tion of total outlay in both the education and health sectors. However, what is important is that external support has played a catalytic role in trying out new strategies.

One important area where donor support has made a difference is in mainstreaming gender issues and integrating participatory processes in the social sector programmes. This is indeed no mean achievement – especially in areas where women have little voice and in a society where the poor did not always benefit from the development process. Similarly, locating development action within a larger framework of human rights and social justice has also been a valuable input.

6.3 Recommendations – Health and Nutrition

These recommendations are based on a series of one-to-one discussions with government officials and donor representatives and two brainstorming meetings with experts[8]. As discussed in the country analysis, there has been no comprehensive assessment of institutional constraints resulting in ineffective implementation of health care services. Multiple parallel programmes have run concurrently, resulting in a blurring of focus. This is particularly true for the RCH programme, where dysfunctionality and inefficiencies in the larger institutional framework has emerged as *the* bottleneck. The main objective of decentralised planning is to enable the system to make a self-assessment of capacity to deliver quality services and respond to emerging needs of the people. It is internationally acknowledged that this is an effective way to gear the entire system into becoming client-centred and sensitive. The secret of successful programmes in the government and non-governmental sector is good strategic management to optimise the use of all the resources (human, financial and material) – ensuring a 'fit' between services needed by the community, the service delivery system and the overall administrative structure. One of the main problems is that this 'fit' either does not exist or has broken down. The value of decentralised (bottom-up) planning is that this 'fit' can be carefully planned and nurtured.

For example, experience in the South Asian region has demonstrated that the mainstay of our health delivery system is the paramedical worker, who is the only one who can deliver services to poor rural and urban women. This implies that enhancing clinical and diagnostic skills of nurse-midwives and technical/lab assistants (for diagnostic support) should logically be a priority, especially when experience has also shown that higher skills lead to greater self-confidence, community acceptance and effectiveness. Unfortunately, this issue has not been addressed strategically. Grassroots organisations argue that unless planning begins with an assessment of the needs of ordinary people it will remain unaddressed.

Planning is the coming together of diagnosis, strategy development and priority setting. Sida's support to the Government of India could focus on exploring appropriate strategies to make the system become more responsive to the needs of the poor – especially poor women. This is in keeping with Sida's mandate to strengthen community involvement and participatory approach anchored in a human rights and gender sensitive framework.

The World Bank, the European Commission and the DFID expressed positive interest in collaborating/working with Sida. It is indeed noteworthy that all the donors we spoke to emphasised the importance of addressing systemic issues in the health system. They pointed out that project based approaches have not worked and across-the-board health system issues discussed in Section 3 above have come in the way of effective implementation of projects. For example getting doctors to work in rural areas is a systemic issue beyond the scope of specific projects.

[8] Discussions were held with Mr Gautam Basu, Joint Secretary, MOHFW, GOI and representatives of the World Bank, DFID, European Commission and WHO. Two brainstorming meetings were convened – the first one in New Delhi on 31 January 2002 and the second one in Chennai on 28 and 29 March 2002. These recommendations were discussed and finalised in Chennai by the group of experts, namely: Birger Carl Forsberg (Consultant to Sida, Stockholm), Gita Sen (IIM Bangalore and HealthWatch), Leela Visaria (HealthWatch), Rama Baru (CSSM, JNU, New Delhi), Ravi Duggal (Cehat, Mumbai and HealthWatch), Sunil Nandraj (WHO, New Delhi), V R Muraleedharan (IIT Madras) and Vimala Ramachandran (Educational Resource Un it and HealthWatch, New Delhi and Jaipur).

6.3.1 District focused operations in the health system

It is recommended that Sida focus on a few districts in the country and supports a bottom-up approach to identify needs of the people and work upwards. The following planning guidelines could be considered:

- Start with addressing constraints to effective implementation of the existing health (including RCH) programme from a *gender and equity angle* and work in a focused manner to identify constraints and opportunities in a systematic fashion. This would highlight what could be achieved and at which particular level in the system.
- The programme itself could begin with a community needs assessment project, a participatory tool that has been accepted 'officially' as part of the national programme but is yet to be operationalised/implemented in the spirit in which it was originally conceived. The five-fold objectives of the Community Needs Assessment approach (C.N.A) are[9]:
  - Involve the community in assessing their health status and searching for ways and means to tackle various issues and problems, with concerted efforts made to involve women in the process;
  - Educate the community about basic health and reproductive health/family planning issues, thereby making them aware of problems such as: maternal and child health issues (including mortality and morbidity), the risks, mode of transmission of a range of infections/diseases and what they can do to prevent it and seek medical care where necessary.
  - Encourage male involvement and male participation in reproductive health care (including contraception) and child health schemes.
  - Enable the ANM and M-MPW to create a support group in the form of a Village Health Committee or Mahila Swasthya Sangh. Such a village support group would strengthen their ability to provide services.
  - Generate a realistic plan (including goals and targets) from the village right up to the District.
- Sida could choose a limited number of districts (say 4 to 6 across the country) – choosing across states, tribal districts, under-served districts and also some with a positive reform environment. The RCH Household and Facility Survey could be used to define criteria and help in selection of districts.
- Sida's input could cover some elements that are common across districts and some that are specific to the district, going up to the first referral level in areas where it is needed or work in collaboration with other donors/NGOs to strengthen referral.
- Introduce specific initiatives (with private sector/NGO/public sector) on insurance/community financing issues and pilot them in select districts. Working in different socio-economic situations could help generate alternative approaches to risk-pooling and health security/ safety net.
- Sida could bring into this programme a strong orientation/emphasis on enhancing the skills, confidence and status of nurse-midwives and/or ANMs as the case may be. Some states like Chattisgarh are already working towards a three-year medical education programme and Sida is infact planning for similar initiatives with nurse-midwives in Medak (Andhra Pradesh) and Bidar (Karnataka) in collaboration with UNICEF).

[9] This is another acronym for micro-planning through Participatory Rural Appraisal techniques.

– Bring into the fold the unfinished agenda of adolescents (counselling and services), male involvement and male responsibility.

– Given that many of the problems with the RCH project are related to under-utilisation of resources, mid-term reviews of the RCH programme have pointed out that under-utilisation is linked to the inability of the government to begin with C.N.A and work upwards. Addressing utilisation issues of both resources and public services could be a key focus of the programme. The aim here is to enhance the utilisation of services by the poor.

– Sida could also explore public – private linkages (along the lines of the experience of Tamil Nadu in harnessing resources from local business/private sector for infrastructure improvement and augmenting the availability essential medical equipment[10]).

– Sida could initiate this in districts where there are strong women's programmes or effective NGOs – to build the pressure from within.

There is convincing evidence on inadequate coverage and level of utilisation of RCH services by the poor and also less than optimal utilisation of funds (Mid Term review of the Ninth Five Year Plan, Planning Commission, GOI). This has happened because of two reasons: (1) the core of the RCH project was supposed to start with C.N.A – but this has not happened, and (2) systematic approaches to improving quality and access and efforts to systematically mainstream gender and equity concerns are weak. As a result the RCH programme has remained fragmentary.

While the details on project formulation could be worked out at an appropriate time, at this stage it is important to acknowledge that this programme would be implemented through the government. Sida could work towards a Memorandum of Understanding with the GOI whereby a national level apex advisory committee (constituted by the government) could provide technical support, help in working through the details and also ensure that the programme is on track.

We already have the RCH facility and household surveys and this provides essential baseline information. This is a good base for selection of districts. This information could be used along with NFHS II and Census 2001 information.

If the Sida assisted programmes are to work through the existing RCH societies then it would be valuable to explore whether the MOU for Sida assistance includes clauses/mechanisms to ensure genuine decentralisation (not just delegation of responsibility). This is in keeping with Sida's mandate.

As a run up to detailed planning and negotiation, there is an urgent need to understand the effectiveness and functioning of district and state level RCH project societies. This should include issues of autonomy, genuine decentralisation, interface with local self-government institutions (Panchayati Raj Institutions) and their interface with the main line department. A status report based on the experience of a range of autonomous bodies established under the aegis of externally aided projects would be valuable. It may be recalled that the first such society was established in the education sector for the implementation of the Sida assisted Shiksha Karmi Project in Rajasthan.

6.3.2 Nurse-midwife training and advocacy:

Sida could work with the national government to develop and refine the idea of creating a pool of nurse-midwives who could be the first line of caregivers in rural areas and urban slums/migrant settlements. To this end Sida could begin with advocacy/preparing the ground in India, in collaboration with a pre-

[10] For more details see HealthWatch (1999): The Community Needs Based Reproductive and Child Health In India – Progress and Constraints.

mier institution in Sweden. Advocacy would include discussions with key opinion makers and practitioners, the medical education establishment, the medical council, etc. Sweden could bring into this process their experience and expertise – to convince the medical community not only of the need for nurse-midwives but also the importance of enhancing their status and their skills/confidence to be able to function in the community.

The programme could also explore the possibility of facilitating the establishment of a council of nurse-midwives. This may not necessarily be a part of the existing nursing council, as the existing council essentially represents hospital-based nurses and not community based nurse-midwives.

Planning and preparing the ground for this in India would involve intensive advocacy to ensure that girls from rural areas and from disadvantaged groups do not drop out at the primary or middle level of education, but are able to reach at least up to grade 10 or 12. This effort could be complemented by forging forward linkages in the educational programme, to enable school drop-outs (mostly adolescent girls) to resume their education and go up to high school level in an accelerated learning programmes (somewhat along the lines of the Mahila Shikshan Kendra of the Mahila Samakhya Programme and Mahila Shikshan Vihar of the Lok Jumbish Project). Sida could consider dovetailing the girls' education programme to prepare in enabling girls to reach high school level (especially in tribal areas), so that they can then take advantage of nurse training programmes.

Since the Government of Chattisgarh is exploring the possibility of introducing a three-year medical education programme, this could provide Sida with a window of opportunity. Hands on work in curriculum development, technical support, development of protocols, licensing etc. could be worked out in collaboration with a Swedish institution.

6.3.3 Establishing Best Practices Inventory in the HSR process in India:

Sida could explore the possibility of supporting a (non-government) network to monitor the process of HSR. This could be done in collaboration with a premier institutions/network that could become the nodal point for an informed debate on sector reforms.

The mandate could include tracking, monitoring (including evaluation) and documenting (best practice inventory) progress. Working towards best practices inventory (both within the project district and also across the country) could facilitate the emergence of "learning programmes" where field experiences feed into research and vice-versa. Sida could effectively use limited resources by setting the agenda for dialogue on sector reforms – in a gender sensitive and pro-poor framework.

6.4 Recommendations – Education and Literacy:

It is imperative that any fresh attempt at programmatic interventions in basic education should not attempt to work in isolation and thereby add one more scheme to the plethora of existing schemes. It is equally important that it draw appropriate lessons from past efforts. There have been major interventions in the last decade, in particular the DPEP programmes (supported by a consortium of donors), and more recently the Lok Sabha ratification of the 93rd Constitution Amendment Bill granting basic education to all children in the age groups 6-14 as a fundamental right. Besides these, the Indian government has launched the ambitious Sarva Shiksha Abhiyan (SSA), which aims to provide quality elementary education to all children in the 6-14 age group by 2010. The objectives of SSA are to ensure that:

- All children in formal school, Education Guarantee Scheme, Alternative Schools or 'back to school' camp by 2002;
- All children complete five years of primary schooling by 2007;

– All children complete eight years of schooling by 2010;

– Bridge all gender and social category gaps at primary stage by 2007 and at elementary level by 2010;

– Universal retention.

The SSA provides a broad convergent framework for implementation of UEE and has the necessary budget provisions for strengthening vital areas to achieve UEE. All investments for elementary education from central and state plans will merge into the SSA programme within the first few years of the decade.

SIDA too has considerable experience through its Shiksha Karmi and Lok Jumbish programmes, both of which though located in one state (Rajasthan), significantly influenced thinking and programming in the area. Variations of the Shiksha Karmi Project have influenced government policy with respect to hiring of local teacher through community participation, introduction of parateachers in areas where teacher absenteeism/non-availability (due to lack of trained teachers) is serious, mainstreaming children from SK schools into regular schools after class V. Similarly the Lok Jumbish experience has resulted in greater acceptance of school mapping and micro-planning to identify out-of-school and school dropouts, block level planning, special strategies for difficult to reach children, building construction and maintenance work by the local community, and involvement of other actors – both state and non-state – in the educational enterprise. In addition, Lok Jumbish's experience with its special focus on the girl child and marginal/minority groups has found space in many other programmes across the country. This is a worthwhile example of learning transfer. SIDA, as an external donor/partner, could consider the following two options:

6.4.1 National Programme for Girls education:

The Working Group Report on Elementary and Adult Education for the Tenth Plan (2002-2007) recognises the importance of mainstreaming gender concerns in education and recommends an extension and deepening of the Mahila Samakhya approach. More specifically, it recommends emphasis on recruitment of women teachers and augmentation of teacher training facilities for women, greater participation of women in VECs and PTAs, strengthening infrastructural facilities in schools for girls alongside provision of childcare facilities. Since it recognises the importance of increasing gender sensitivity across all schemes and sectors, it proposes setting up a National Resource Centre to backstop State Councils for Educational Research and Training (SCERTs) and District Institutes of Education and Training (DIETs) in different states. Finally there the two new schemes, the National Programme for the Education of Girls at the Elementary Level (NPEGEL) and Kasturba Gandhi Swatantra Vidyalaya (KG SV) to set up special schools for the girl child belonging to SC.ST.OBC and minority communities in low female literacy districts.

– Sida could consider focusing on the girl child through the elementary education cycle alongside addressing the problems of the adolescent girls. Without negating the advances made in bridging the gender gap in education, the stark fact remains that the median years of schooling for girls stands at an abysmal 1.3 years, with the situation far worse in educationally backward areas and within socially deprived groups. Fortunately, the recognition of the need for girls' education is widely accepted, reflected in a greater demand for it. During discussions with the Department of Education, MHRD, and GOI – officials indicated that they would welcome Sida support for NPEGEL. Being a national programme focusing on 200 educationally backward blocks, Sida's support would go a long way in developing context specific strategies in different parts of the country.

– Recognising that there are no quick solutions or magic formulae to address fundamental problems of access and equity alongside gender disparity on the one hand and quality, content and relevance on the other, the girls' education programme could address different set of components. Compo-

nents like physical access, mobilisation, quality, teacher management and pedagogic renewal would together ensure confluence and synergy. An integrated approach is necessary for meaningful change and lasting/sustainable impact. Also just five years of primary education – class I to V, age 6-11, is insufficient to ensure significant value addition or in many cases even retention of basic literacy and numeracy, particularly for groups who have historically been denied education. Looking ahead, in the long term, eight years of basic education is essential and needs to be recognised as the basic minimum and also taken as a non-negotiable issue. This non-negotiable principle could be intrinsic to the programme.

– Recognising that primary education is not a stand-alone activity, a girl's education programme could look to forge backward and forward linkages. While pre-school is accepted as a critical input into primary education we have a long way to go before forward linkages beyond the primary stage is accorded the same degree of importance. Availability of relevant and good quality vocational and life skill educational opportunities is essential to generate the necessary momentum for primary and upper-primary education. The age span we are looking at is 3 to 18, with one level feeding into the other and higher levels creating the necessary suction effect for earlier stages. Therefore a girls' education programme would offer ample scope for focusing on adolescent girls by strengthening Mahila Shikshan Kendras, and to empower, motivate and strengthen the skills and confidence of women teachers and strengthen community-school linkages through women's groups (Mahila Samoohs). The demand for women teachers/trainers is likely to escalate sharply with many states deciding that all new appointments as parateachers will be women. Working in tandem with the Mahila Samakhya Programme, which has the broader focus of women's empowerment as a goal, Sida's support to NPEGEL could be strategically important.

6.4.2 Context specific strategies for child labour and working children:

Focus on and develop ongoing work with special focus groups like working children, both in urban and rural areas. While the experience with rural working children has been more extensive, inadequate attention has been given to the special problems of the urban slum/street/working children. However, the experience of groups like PRATHAM in Mumbai, working in collaboration with the Municipal Corporation to both strengthen in-school facilities and also offer special courses to out-of-school street/slum children to draw them into schools (now expanded to many other cities through the India Education Initiative), offers possibilities of a meaningful partnership. It is also significant that this process involves local corporate support – both pecuniary and managerial.

It is significant that the Approach Document to the Tenth Plan recognises that current EE programmes neglect the urban deprived, not only because a vast majority of children live in rural areas but because of a mistaken perception that urban areas are well serviced because of the presence of private schooling. These, however, reach out only to the relatively privileged.

The new plan thus talks of:

– Developing a reliable data base covering all cities, ensuring convergence between various service providers,

– Strengthening grassroots and community based organisations for plan formulation and implementation,

– Relocation of government and local body schools closer to residential colonies and settlements of the urban poor,

– Simultaneously setting up new EGS schools and urgently introducing bridge courses, transition classes and camp schools to meet problems of adjustment.

– Finally, it recommends greater involvement of private sector schools, possibly through starting evening classes. It also talks of strengthening various incentive schemes, since most children who drop out of school belong to low-income groups.

During discussions the Department of Education, MHRD, and GOI officials pointed out that they are committed to allocating sufficient resources for the programme through SSA and are also making efforts to mobilise external resources for it. Sida, with other donors, could partner and support this initiative.

6.4.3 Concluding remarks:

In conclusion, SIDA as a small donor should seek to focus on programmes wherein it might enjoy some leverage in particular for the girl child and other marginalized groupings. To facilitate easier mainstreaming special care must be taken that the programmes developed are based on strengthening the rights of children and are cost-effective. Given Sida's track record in the education sector, it is ideally placed to work with the national government to bring girls education and equity issues to the forefront. Programme details could be worked out at an appropriate stage, however, at this stage it is indeed heartening to note that Government of India is open to working with Sida at the national level and is not contemplating limiting Sida's involvement to a few states.

As discussed in earlier sections it would be important to negotiate convergence and synergy between the education and health programmes supported by Sida. Such a strategy would be enriching for both sectors.

Annexure

Table I

Sex ratios, 1991 and 2001 (major states)

State	All ages 1991	All ages 2001	Age (0-6) 1991	Age (0-6) 2001
All India	927	933	945	927
Andhra Pradesh	972	978	975	964
Assam	923	932	975	964
Bihar	907	921	953	938
Chhatisgarh	985	990	984	975
Gujarat	934	921	928	878
Goa	967	960	964	933
Haryana	865	861	879	820
Himachal Pradesh	976	970	951	897
Jammu & Kashmir	896	900	NA	937
Jharkhand	922	941	979	966
Karnataka	960	964	960	949
Kerala	1036	1058	958	963
Madhya Pradesh	912	920	941	929
Maharashtra	934	922	946	917
Orissa	971	972	967	950
Punjab	882	874	875	793
Rajasthan	910	922	916	909
Tamil Nadu	974	986	948	939
Uttaranchal	936	964	948	906
Uttar Pradesh	876	898	927	916
West Bengal	917	934	967	963

Source: Census of India 2001; Paper 1 of 2001 – Provisional Population Totals

Table II

Literacy rates: All India and Major States, 2001

State	Male rate	Female rate	Gap	Decadal increase, male rate	Decadal increase, female rate	Increase ranked in Descending. Order	
						M	F
All India	75.96	54.28	21.68	11.83	15.00		
Andhra Pradesh	70.85	51.17	19.68	15.72	18.45	4	6
Assam	71.93	56.03	15.90	10.06	13.00	11	16
Bihar	60.32	33.57	26.75	8.95	11.58	16	17
Chattisgarh	77.86	52.40	25.46	19.79	24.87	2	1
Gujarat	80.50	58.60	21.90	7.11	9.68	18	18
Goa	88.88	75.51	13.37	5.24	8.42	19	19
Haryana	79.25	56.31	22.94	10.16	15.84	10	8
Himachal Pradesh	86.02	68.08	17.94	10.61	15.82	9	9
Jammu & Kashmir	65.75	41.82	23.93	NA	NA	NA	NA
Jharkhand	67.94	39.38	28.57	12.14	13.86	7	11
Karnataka	76.29	57.45	18.84	9.03	13.12	15	15
Kerala	94.20	87.86	6.34	0.58	1.69	20	20
Madhya Pradesh	76.80	50.28	26.52	18.26	20.93	3	3
Maharashtra	86.27	67.51	18.75	9.71	15.20	14	10
Orissa	75.95	50.97	24.98	12.86	16.29	6	7
Punjab	75.63	63.55	12.08	9.97	13.14	12	14
Rajasthan	76.46	44.34	32.12	21.47	23.90	1	2
Tamil Nadu	82.33	64.55	17.78	8.58	13.22	17	13
Uttaranchal	84.01	60.26	23.75	11.22	18.63	8	4
Uttar Pradesh	70.23	42.98	27.25	15.40	18.61	5	5
West Bengal	77.58	60.22	17.35	9.77	13.66	13	12

Source: Census of India, 2001; Paper 1 of 2001 – Provisional Population Totals, Series 1– India: Statement 35, pp.126

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Appendix: Terms of Reference

Preparation of background document for country strategy paper on the social sector reforms in India.

Background
The growing trend among the donor community is to adopt the Sector Side Approaches (SWAp) principles for the establishment of long-term development assistance at sector level, based on visible and real government ownership, and improved co-ordination among themselves. In the last ten years, especially since India went in for structural adjustment, there has been considerable interest in addressing systemic barriers to effective implementation of social sector programmes.

Sida intends to take a more active role in applying SWAp principles and Sida is giving due consideration to this relatively recently developed concept. The basic assumption underlying the Swedish development co-operation with India is that assistance should be geared towards initiatives that clearly bring out the value-added of the use of the Swedish funds and expertise and not towards filling gaps in investments and sector programmes.

Objective of the Review
Sida is in the process of developing a Country Strategy for development co-operation between Sweden and India for the period 2003-2007. The Country Analysis document will include a section on the social sectors reform situation in India. The Country Strategy document will contain suggestions on what opportunities exist for Sida to support the social sectors reform.

This review shall provide the necessary information for inputs into the Country Analysis document (overall current and future situation) and the Country Strategy document (possible future interventions by Sida).

Specific tasks
The consultants shall

- review and analyse the social sector reform initiatives in India;
- elaborate on whether the sector reforms have made any effect on the health and literacy outcomes and overall well-being of the people and what effects the reform might have in the future;
- identify the most important areas in need of reform in the health and education sectors in India; and
- make recommendations to Sida on priorities, principles and possible areas for Swedish support during 2003-2007, given our strategy as mentioned above .

Methodology
The consultants shall

- undertake a desk review of important published and unpublished material on social sector reforms in India;
- consult with experts, practitioners and development partners.

The entire exercise shall be undertaken within a maximum of fifty working days spread over ten weeks duration.

Reporting

A draft report shall be submitted to DCS no later than 15 April 2002. The draft report shall be shared with a small group of relevant people for comments. The final report shall be submitted to the Development Co-operation Section (DCS) at the Embassy, no later than 30 April 2002.

The report shall not exceed a maximum of 30 pages and should include an Executive Summary and Conclusions and Recommendations. The consultants should quote the sources or attach excerpts from such sources whenever possible as well as list of people interviewed.

The final version shall be submitted in three copies and on a diskette. The report should be written in Word 6 or in a compatible format.

Team Composition

A team comprising of experts from the field of social sector policies, reforms and development shall be identified for the review. A local agency will be hired for the assignment who will be responsible to subcontract subject experts as required. An international consultant, with expertise and experience in reforms and policies, will join the team for a period of two weeks during the review.

Time Plan

The time frame for the assignment will be a total of 50 mandays spread over ten weeks, from 20 February to 30 April 2002. The assignment shall be effect from the date of signing the contract.

Halving poverty by 2015 is one of the greatest challenges of our time, requiring cooperation and sustainability. The partner countries are responsible for their own development. Sida provides resources and develops knowledge and expertise, making the world a richer place.

SWEDISH INTERNATIONAL
DEVELOPMENT COOPERATION AGENCY

SE-105 25 Stockholm Sweden
Phone: +46 (0)8 698 50 00
Fax: +46 (0)8 698 56 15
info@sida.se, www.sida.se